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ABSTRACT

Presented is the transcript of testimony provided at hearings (April 6 and 7, 1977) before the subcommittee on child and human development of the Committee on Human Relations of the United States Senate on Extension of the Child Abuse Prevention and Treatment Act (Public Law 93-247). Statements are included of individuals representing such organizations as the National Center for the Prevention and Treatment of Child Abuse and Neglect, New York City Child Welfare Services, Parents Anonymous, National Committee for Prevention of Child Abuse, and National Association of Social Workers. Appended are additional statements from such organizations as the American Academy of Pediatrics and the American Humane Association. Background materials include 15 articles on the nature, causes, and treatment of child abuse and neglect. (DB)

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EXTENSION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT, 1977

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON
CHILD AND HUMAN DEVELOPMENT

OF THE

COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE
NINETY-FIFTH CONGRESS

FIRST SESSION

ON

EXAMINATION OF THE PROGRAM FOR THE PREVENTION, IDENTIFICATION, AND TREATMENT OF CHILD ABUSE AND NEGLECT

APRIL 6 AND 7, 1977

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CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

April 6, 1977

Page

Gelles, Richard J., Ph. D., associate professor of sociology, University of Rhode Island, Kingston, R.I. 3

Kempe, C. Henry, Ph. D., professor of pediatrics and microbiology at the University of Denver and director of the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colo. 34

Zigler, Edward Ph. D., research analyst, Yale University, New Haven, Conn. 38

Newberger, Eli H., M.D., director, Family Development Study, Children's Hospital Medical Center, and assistant professor of pediatrics, Harvard Medical School, Boston, Mass. 42

Parry, Carol, administrator, New York City Child Welfare Services, New York, N.Y. 107

Benet, child abusive parent representative 115

Beverly, child abusive parent representative 119

Pressma, Donna, A.C.S.W., director, protective services, department of children and youth services, Hartford, Conn.; Barbara Sabol, director, services to children and youth, Topeka, Kans.; and Anthony Shaw, M.D., chief, pediatric surgery, University of Virginia and chairman, Governors commission on abuse and neglect, Charlottesville, Va., a panel 123

April 7, 1977

Martinez, Hon. Arabella, Assistant Secretary for Human Development, Department of Health, Education, and Welfare, accompanied by Saul Rosoff 158

Bricker, Stephen W., staff attorney, juvenile rights project, American Civil Liberties Union, Richmond, Va.; Brian Fraser, executive director, National Committee for Prevention of Child Abuse, Chicago, Ill.; and Vanette Graham, National Association of Social Workers, Washington, D.C., accompanied by Leila Whiting, project director, child abuse and neglect training project, a panel 205

STATEMENTS

American Civil Liberties Union, Stephen Bricker, staff attorney, juvenile rights project, prepared statement 212

Benet, child abusive parent representative 115

Beverly, child abusive parent representative 119

Bricker, Stephen W., staff attorney, juvenile rights project, American Civil Liberties Union, Richmond, Va.; Brian Fraser, executive director, National Committee for Prevention of Child Abuse, Chicago, Ill.; and Vanette Graham, National Association of Social Workers, Washington, D.C., accompanied by Leila Whiting, project director, child abuse and neglect training project, a panel 205

  Prepared statement 212

Gelles, Richard J., Ph. D., associate professor of sociology, University of Rhode Island, Kingston, R.I. 3

  Prepared statement 10

Kansas Department of Social and Rehabilitation Services, Barbara J. Sabol, director, division of services to children and youth, prepared statement 134

Page

Kempe, C. Henry, Ph. D., professor of pediatrics and microbiology at the University of Denver and director of the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colo 34

Martinez, Hon. Arabella, Assistant Secretary for Human Development, Department of Health, Education, and Welfare, accompanied by Saul Rosoff 158

  Prepared statement 172

National Association of Social Workers, Inc., Vanette Graham, chairperson, The Children's Coalition, prepared statement 246

National Committee for Prevention of Child Abuse, Brian Fraser, executive director, prepared statement 227

Newberger, Eli H., M.D., director, Family Development Study, Children's Hospital Medical Center, and assistant professsor of pediatrics, Harvard Medical School, Boston, Mass 42

  Prepared statement 47

Parry, Carol, administrator, New York City Child Welfare Services, New York, N.Y 107

Pressma, Donna, A.C.S.W., director, protective services, department of children and youth services, Hartford, Conn.; Barbara Sabol, director, services to children and youth, Topeka, Kans.; and Anthony Shaw, M.D., chief of pediatric surgery, University of Virginia and chairman, Governors commission on abuse and neglect, Charlottesville, Va., a panel 123

  Prepared statement 126

Shaw, Anthony, M.D., chief of pediatric surgery, University of Virginia and chairman, Governors' commission on abuse and neglect, Charlottesville, Va., prepared statement 145

Zigler, Edward, Ph. D., research analyst, Yale University, New Haven, Conn 38

ADDITIONAL INFORMATION

Articles, publications, etc.:

  Child Health in America: Toward a Rational Public Policy, Eli H. Newberger, Carolyn Morre Newberger, and Julius B. Richmond, from Health and Society, Summer 1976 57

Questions and answers:

  Questions submitted to Department of Health, Education, and Welfare from Senator Cranston, and answers supplied by HEW 186

APPENDIX

Additional statements:

  American Academy of Pediatrics, committee on the infant and preschool child, Rowland L. Mindlin, FAAP, chairman, prepared statement 287

  American Humane Association, Vincent De Francis, J.D., director, children's division, prepared statement 276

  Anderson, Hon. Wendell R., a U.S. Senator from the State of Minnesota, prepared statement 267

  Berkeley Planning Associates, Berkeley, Calif., Anne Harris Cohn, DPH, project director, and Frederick C. Collignon, Ph. D., principal investigator, prepared statement 289

  California State Department of Health, Jerome A. Lackner, M.D., director of health, prepared statement 274

  City of New York, human resources administration, department of social services, special services for children, New York, N.Y., Carol J. Parry, assistant commissioner, prepared statement 305

  H.E.L.P. Resource Project, Baltimore, Md., Curtis L. Decker, project director, prepared statement 285

  National Coalition for Children's Justice, Kathleen Lyons, Washington representative, prepared statement 299

  National Council of Jewish Women, Esther R. Landa, national president, prepared statement 279

  Texas State Department of Public Welfare, Raymond W. Vowell, commissioner, prepared statement 261

  York-Poquoson Social Services, Grafton, Va., Elizabeth H. Copeland, RSW, director, prepared statement 282

Additional communications:
  Brademas, Hon. John, a Representative in Congress from the State of Indiana, chairman, Subcommittee on Select Education, Committee on Education and Labor, U.S. House of Representatives, from T. N. Tangedahl, ACSW, executive director, Social Service Board of North Dakota, Feb. 18, 1977 ____ Page 392
  Cranston, Hon. Alan, a U.S. Senator from the State of California, from:
    Arredondo, Sonja L., administrative supervisor, Hidalgo County Child Welfare Unit, Edinburg, Tex., May 10, 1977 ____ 382
    Beal, Frank S., secretary, Pennsylvania Department of Public Welfare, Harrisburg, Pa., May 27, 1977 ____ 389
    Brinkman, Gloria, consultant, Montana State Social and Rehabilitation Services, May 5, 1977 ____ 365
    Burdick, Hon. Quentin N., a U.S. Senator from the State of North Dakota, Mar. 2, 1977 ____ 391
    Cundiff, Barbara S., consultant, division of family and children services, Georgia Department of Human Resources, Mar. 15, 1977 ____ 371
    Fountain, Suzanne, social work supervisor, and D. F. Wyron, chief social work supervisor, Virginia Department of Social Services, Portsmouth, Va., May 25, 1977 ____ 388
    Gibson, Florence R., A.C.S.W., executive director, Family Service Association of Licking County, Newark, Ohio, May 5, 1977 ____ 376
    Groberg, David H., Ph. D., regional director, Idaho Department of Health and Welfare, Idaho Falls, Idaho, May 23, 1977 ____ 377
    Grossman, Moses, M.D., president, San Francisco Child Abuse Council, and professor of pediatrics, University of California, May 6, 1977 ____ 366
    Haeuser, Adrienne A., director, school of social welfare, University of Wisconsin, Milwaukee, Wis., June 14, 1977 ____ 383
    Haley, R. Nancy, A.C.S.W., executive director, Northampton County Children's Bureau, Easton, Pa., May 10, 1977 ____ 368
    Hammell, Charlotte L., director, child care service, Delaware County, Media, Pa., June 9, 1977 ____ 385
    Hanus, Barbara A., A.C.S.W., chief, bureau of child and family services, New Hampshire State Department of Health and Welfare, May 10, 1977 ____ 367
    Hudgins, Daniel C., A.C.S.W., Durham County Department of Social Services, Durham, N.C., June 8, 1977 ____ 378
    Huerta, John L., director, Arizona Department of Economic Security, Phoenix, Ariz., June 15, 1977 ____ 380
    Jewett, Anne, county program director, service division I, Fulton County Department of Family and Children Services, Atlanta, Ga., Apr. 6, 1977 ____ 361
    Jornlin, Robert E., director, social service department, Contra Costa County, Concord, Calif., May 25, 1977 ____ 384
    Kempe, C. Henry, M.D., professor of pediatrics and microbiology, director, National Center for Prevention and Treatment of Child Abuse and Neglect, Apr. 11, 1977 ____ 310
    Klein, Milton G., director, Idaho Department of Health and Welfare, Boise, Idaho, May 17, 1977 ____ 272
    Martinez, Arabella, Assistant Secretary for Human Development, Department of Health, Education, and Welfare, Apr. 4, 1977 (with enclosures) ____ 396
    Newberger, Eli H., M.D., director, family development study, The Children's Hospital Medical Center, Boston, Mass., Apr. 12 1977 ____ 358
    Reid, Dolores B., A.C.S.W., deputy director, Illinois Program Support Services, Springfield, Ill., July 8, 1977 ____ 387
    Stout, Gary E., administrator, children's services, Clinton County, Pa., May 2, 1977 ____ 374
    Tuszynski, Ann, A.C.S.W., director, family life center, Family Service Association of Atlantic County, N.J., May 6, 1977 ____ 375

Additional communications—Continued

Cranston, Hon. Alan, a U.S. Senator from the State of California, from—Continued

Page

- Tweraser, Gene, assistant director, SCAN Service, Inc., Fayetteville, Ark., May 13, 1977 — 369
- Ward, Robert H., director, Department of Human Resources, State of North Carolina, Apr. 25, 1977 — 370
- Wiley, Paul R., director, Riverside County Department of Public Social Services, Riverside, Calif., May 6, 1977 — 386
- Zimmerman, Anne, R.N., president, American Nurses Association, Inc., Kansas City, Mo., Apr. 1, 1977 — 363

Hirsch, Sharlene P., M.D., coordinator, Educaton and Human Development Group, HEW Team, Transition Planning Group, from Robert F. Bennett, Governor, State of Kansas, Topeka, Kans., Dec. 6, 1976 — 268

Martinez, Hon. Arabella, Assistant Secretary for Human Development, Department of Health, Education, and Welfare, from Alan Cranston, Chairman, Subcommittee on Child and Human Development, Mar. 25, 1977 — 395

Background materials:

- AMA Symposium—The Battered Child, by Vincent J. Fontana, M.D., director of pediatrics, Vincent's Hospital and Medical Center of New York — 498
- Battered Babies: Their Screams of Terror Go Unheard, by Helene Tanous, M.D., and Beverly Vance, M.D. — 470
- Child Abuse, by Jean Yavis Jones, Education and Public Welfare Division, Congressional Research Service, Library of Congress, Apr. 2, 1975 — 512
- Child Abuse—Principles and Implications of Current Pediatric Practice, by Eli H. Newberger, M.D., and James N. Hyde, Jr., M.S., from Pediatric Clinics of North America, vol. 22, No. 3, August 1975 — 435
- Child Abuse—Symptom of a Violent Society, by Vincent J. Fontana, M.D., from Council Woman, winter 1977 — 427
- Child Abuse and Neglect—Legislation and Issues, Congressional Research Service, Library of Congress — 412
- Highlights of 1974 National Data, National Clearinghouse on Child Neglect and Abuse, Children's Division, American Humane Association — 421
- Implementation of Public Law 93–247, the Child Abuse Prevention and Treatment Act, report of the Department of Health, Education, and Welfare to the President and Congress of the United States, August 1975 — 587
- Keeping Records on Suspected Child Abuses, by Alan N. Sussman, from Council Woman, winter 1977 — 433
- Knowledge and Epidemiology of Child Abuse: A Critical Review of Concepts by Eli H. Newberger, M.D., and Jessica H. Daniel, Ph. D., from Pediatric Annals, March 1976 — 490
- Myth of the Battered Child Syndrome: Focus on Parents' Inability to Nurture Child, by Eli H. Newberger, M.D., from Current Medical Dialog, April 1973 — 494
- Reducing the Literal and Human Cost of Child Abuse: Impact of a New Hospital Management System, by Eli Newberger, John J. Hagenbuch, Nancy B. Ebeling, Elizabeth Pivchik Colligan, Jane S. Sheehan, and Susan H. McVeigh, from Pediatrics, May 1973 — 460
- Today's Abused Children Are Tomorrow's Abusive Parents, from Council Woman, winter 1977 — 425
- Why Do Parents Harm Their Children? by Douglas J. Besharov and Susan H. Besharov, from Council Woman, winter 1977 — 430
- Working with High-Risk Families: Family Advocacy and the Parent Education Program, by Jessica H. Daniel and James N. Hyde, Jr., from Children Today, November-December 1975 — 456

EXTENSION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT, 1977

WEDNESDAY, APRIL 6, 1977

U.S. SENATE,
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT
OF THE COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m. in room 4200, Dirksen Senate Office Building, Senator Donald W. Riegle, Jr. presiding pro tempore.

Present: Senators Cranston, Riegle, and Hayakawa.

Senator RIEGLE. The subcommittee will come to order.

Let me just say at the outset that I am Senator Riegle, sitting in for Senator Cranston today, and I apologize to you for starting later than we had intended. I had a responsibility today to introduce a couple of subcabinet officers before the Senate Agriculture Committee and I have just completed that task. That is the reason I am here later than I had intended.

Now Senator Cranston—who, as I will describe shortly, had another matter which prevents him from being here—has asked that I read for him his opening statement, which I will now do.

OPENING STATEMENT OF SENATOR CRANSTON

Senator CRANSTON. I regret very much that an irreconcilable scheduling conflict which arose at the last minute prevents me from being here to open these important hearings. I have asked Don Riegle, and he has very kindly agreed, to open these hearings and read this opening statement on my behalf until I can return from the other two meetings I must attend in the early part of the morning. I will, of course, be reviewing all the testimony very carefully as we move ahead with subcommittee consideration of extension of this legislation.

In January of this year we observed the third anniversary of our national commitment to the prevention, identification, and treatment of one of the most complex and elusive of human problems—child abuse and neglect.

The Child Abuse Prevention and Treatment Act was passed in January 1974, by a vote of 57 to 7 in the Senate and 354 to 36 in the House of Representatives. These votes demonstrated truly bipartisan support for a Federal role to deal with this critical issue.

When the subcommittee first held hearings on child abuse and neglect in 1973, we learned about the cyclical nature of child abuse in families; about the large number of undiagnosed cases and about the inadequacy of our existing social, legal and health care systems to deal with them.

This learning, which grew out of the pioneering work of a few dedicated researchers and practitioners, formed the basis of the legislation we are reviewing today. As a result of the enactment of this law, the Department of Health, Education, and Welfare created in the Office of Child Development the National Center on Child Abuse and Neglect which conducts technical assistance, research, and information activities.

The Center is also providing support to States and to a wide variety of demonstration projects dedicated to creating and perfecting methods of relieving the terrible pressures which explode into child abuse and neglect in thousands of American families every year.

I want to echo the sentiments of Senator Cranston in terms of my own feelings as a member of this subcommittee and say that I was one of those in the House which voted to pass the act in 1974. So I am very much interested in the review process that we are about to undertake.

In any event, continuing Senator Cranston's statement, he says: Congress was never under the illusion when it established this modest program that it would result in the termination of child abuse and neglect. Rather, the intent in developing the legislation was to heighten awareness of the problem, to improve the focus of the fragmented resources of the Federal Government on the problem and to stimulate creative thinking and programs sponsored by private organizations, local, and State Governments, and the media, as well as the Federal Government.

I think we are well on our way toward accomplishing the goal of public recognition of the problem. We have also made progress toward the more subtle understanding that abuse of a child is not necessarily a pathological act by a hopelessly demented criminal, but, rather, the desperate cry for help of a troubled family.

Many say that a society which does not ensure for every child good health care, challenging education, adequate shelter, nutrition, and clothing is one in which there will always be abusing adults. There is much truth to that. But as we dedicate ourselves to reducing unemployment and to providing comprehensive child and family services, we must also continue our work on behalf of the individual children and families who can be helped by an increased understanding of and focus on the phenomenon of child abuse and neglect.

Today we open hearings designed to evaluate the implementation of the Child Abuse Prevention and Treatment Act, and to determine what changes, if any, should be incorporated into an extension of the legislation.

As you may know, the House Subcommittee on Select Education, chaired by my distinguished colleague, Representative John Brademas, recently held two hearings on the prepared extension of this legislation. We look forward to working closely with our colleagues on the House committee to develop the most effective and timely legislative proposals possible.

It is my hope that the witnesses who testify before us will help to explore a number of issues which have been raised in recent months. These include:

One: What priorities should be reflected in the legislation? What percentage of the resources should be directed to research, to training, to demonstration efforts, to services?

Two: Should we place more emphasis on the prevention of child abuse? Is it in fact possible to prevent child abuse, and, if so, how?

Three: What role should the States play in the program?

Four: What have we learned from the research thus far supported? How can this be reflected in our programs and policies?

Five: Has the National Center carried out the intent of Congress in implementing the legislation?

Six: Should we propose a simple extension of the program for 1 year in order to provide time for planning for improved coordination of all children and family services in the Department of Health, Education, and Welfare? Or should we enact a bill which would incorporate substantial changes which may take several years to implement?

I think that most of us would agree that there is no more dramatic and disturbing expression of the deep frustrating problems faced by American families today than child abuse and neglect. Mr. Urie Bronfenbrenner, one of our most perceptive students of American family life, once said:

> Only by making a commitment to children and families will it be possible to counteract the alienation, distrust and breakdown of a sense of community that follows in the wake of impersonal technology, urbanization, bureaucratization, and their unplanned dehumanizing consequences. . . .

It is my hope that our work here today will take us one step further toward fulfilling that commitment which Dr. Bronfenbrenner has so eloquently challenged us to make.

Our first witness today is Prof. Richard Gelles, and if he is here, would he please come up and be seated?

Dr. Gelles, do you want to identify yourself for the committee and then proceed to make whatever statement you wish to make?

STATEMENT OF RICHARD J. GELLES, PH. D., ASSOCIATE PROFESSOR OF SOCIOLOGY, UNIVERSITY OF RHODE ISLAND, KINGSTON, R.I.

Dr. GELLES. My name is Richard Gelles. I have a Ph. D. in sociology and I am an associate professor of sociology at the University of Rhode Island.

I am going to summarize my written testimony this morning. I have been asked to testify on our research on violence toward children in the United States.

Despite the considerable attention which has been focused on the issue of child abuse and neglect and the significant and lengthly discussions concerning physical punishment of children, valid and reliable data on the incidence and/or prevalence of the use of violence and aggression on children by their parents are almost nonexistent. Those data which are available offer varying estimates of child abuse and suffer from major conceptual, definitional, sampling and measurement problems. That the lack of any precise or valid estimate of the extent of child abuse was considered a serious enough gap in our knowledge about this phenomenon to mandate action is evidenced in the call for a complete and full study and investigation of the national incidence of child abuse and neglect in the law which established the National Center on Child Abuse and Neglect, Public Law 93-247.

My testimony today reports on preliminary data from a national survey, begun in 1976, of violence in the American family. Our goal in undertaking this research effort, which was sponsored by the National Institute of Mental Health, was to provide scientifically reliable estimates of the incidence of violence used by parents on children, children on their parents, husbands and wives on each other, and between siblings. Our research is also designed to examine the factors associated with violence in families and to test theories which attempt to explain violence in family life.

Previous research on physical punishment and violence toward children and child abuse offer incredibly varying statistics. We know between 84 and 97 percent of American parents use physical punishment on their children at some point in the child's development. We know little more than that. We don't know which parent uses violence more, to what sex child and at what age. The estimates of physical abuse of children ranges from 6,000 cases of confirmed abuse found by Dr. Gil in 1968 to 200,000 cases projected by the National Center on Child Abuse and Neglect. However, as Cohen and Sussman concluded in 1975, the most realistic conclusion concerning the incidence of child abuse is that information indicating the incidence of child abuse in the United States still does not exist. It does not exist for a number of reasons:

One: Reported cases of child abuse make up only a fraction of the total number of abused children. The cases that come to public attention represent only a small number of the actual number of children who are abused each year.

Second: The term itself is difficult, if not impossible, to define. Child abuse is a political term which is designed to draw attention to problematic area in our society. It is probably a more political term than scientific term and, as such, it is impossible to define and difficult to measure. Trend data on child abuse simply are nonexistent. The increase in child abuse cases which we see recorded on a monthly and yearly basis is probably due to increased sensitivity to the problem on the part of reporting agencies and a broadening definition of abuse.

Even in an area where there is mandated public attention to each case, the death of a child, we have no real knowledge of how many children are killed each year by parents or caretakers. Estimates range from 300 children to 5,000 each year.

Given the range of statistics and the problems with previous research, we began in 1976 a nationally representative survey of 2,143 families or couples. Of these, more than 2,000 families, 1,146 had a child between the ages of 3 and 17 living at home at the time. Our evaluation of the sample that was drawn by the Response Analysis Corp. indicates that this sample is an adequately representative sample of American families and the results which we report today are accurate within a half to 1 percent, plus or minus.

We interviewed the 2,143 families and asked the subjects how they managed conflicts between themselves and their children. Sixty-three percent of the parents we talked to reported at least one incident of violence ranging from a slap to using a gun or knife in 1975. Seventy-three percent reported violence used at some point in the child's life. As would be expected, the milder forms of violence, such as spankings, slappings or shoves, were the most common. However, our data indicate that between a half and three-quarters of a million American children were beaten up by their parents, that is, a series of blows and punches used on them in 1975. Nearly 1.2 million American children have grown up facing parents wielding lethal weapons, guns and knives, at them at some time in their life.

We attempted to determine how many children were at risk or vulnerable to physical injury in their own homes from their own parents. We have found that 3.6 percent of American children, or more than 1½ million children, were either kicked, bit, punished, beaten up or had a gun or knife actually used on them in 1975. Thus we conclude between 1½ to 2 million children were at risk of physical injury from their parents in 1976.

Preliminary findings indicate that mothers are more likely to use violence than fathers. Sons were the most common victims and younger children were more likely to be struck, while older children were more vulnerable to the dangerous forms of violence, such as beatings, guns and knives.

Our statistics might seem high to some. However, we believe that our data probably underestimates the true level of serious violence in American families. First of all, our research is based on self-reports. We asked the families to actually admit using these forms of violence on their children.

Second, we studied only intact families. If, as some believe, single parent families are more likely to use physical force and violence, then our data again are underestimates.

Last, we studied only families with children between 3 and 17 years of age; and if, as some believe, children under 3 are more vulnerable to physical abuse, then again our data probably underestimates the true level of serious violence in the United States.

Our data do reveal a dangerous and high level of violence toward children in the United States. Even if one were to dispute our definition of violence, which includes slaps and spankings as violence, if you look at the extreme forms of violence you find a very high rate of occurence. For instance, if 1 in 1,000 children in public school had guns and knives used on them, we would consider that to be an epidemic of violence. Because we are studying violence in the home, our statistics are often not viewed as that problematic.

Last, because people actually admitted and reported this information to us, we concluded that many people accept and condone the use of dangerous and damaging forms of violence in raising their children.

I have been asked to discuss the implications of our research and make recommendations based on our research for the future funding of the National Center on Child Abuse and Negligence. The first recommendation is to continue the emphasis on research into the causes of child abuse, with a coordination of Federal research efforts in this area and the area of family violence.

My testimony today was based on research which we hope will yield further insights into the causes of family violence. This research is the product of a 7-year research effort involving three investigators, three universities and numerous federally funded projects. Our knowledge base in the area of child abuse is limited because the research which is needed to build such a base has only recently been started. It would be unrealistic to think that 3 years is a sufficient amount of time to gather and analyze data which would help provide the key to understanding the nature and generative sources of child abuse. It took us 7 years to get to a point where we felt we could begin to measure the incidence and causes of family violence.

We recommend five priority areas of research:

One: We recommend more research projects with smaller grant awards to stimulate innovative exploratory research.

Two: We recommend less reliance on research which uses officially designated cases of child abuse and more use of probability samples and national samples which can be used to assess incidence, prevalence, and causes of various types of abusive behavior.

Three: We recommend research on the official responses to child abuse and family violence which focuses on and evaluates the effectiveness of social service, police, and community responses to children at risk.

Four: We recommend funding of longitudinal studies which can assess change and engage in sophisticated casual analysis of factors which operate outside and within families which may cause abuse.

Five: Lastly, we recommend a more adequate program of soliciting grant applications and reviewing grant proposals which provides the research community with adequate time to prepare proposals and provides for the highest quality review of the proposals submitted.

We also recommend that this program consider the entire scope of violence in the family. Focusing only on the topic of child abuse tends to block out the perception of the family as a social system. Our research indicates that nearly 2 million American couples have used a lethal weapon on one another during their marriage, while more than 2 million couples report a beating between a husband and a wife.

In addition, 2 million children have grown up using a gun or a knife on a sibling. We find these types of violence are highly correlated. Thus, wives who are abused by their husbands tend to turn their violence on their children, who, in turn, use violence on their siblings. We are not saying this is the single cause of child abuse. We know child abuse arises from multiple causes. However, we see the need for effective research and service programs which examine the entire range of family violence and the interrelationship of various types of violence in the home.

We recommend providing funds and assistance in basic service areas. As a group of researchers, we are sensitive to the cry that money should be spent to solve problems, rather than to study them. It would seem that these two enterprises ought not be mutually exclusive. While we do not yet know what causes child abuse, and while more research is necessary before we can adequately treat and prevent abuse, we know now that certain service programs are in need of major resources. For instance, if our data are accurate, then in Rhode Island alone, if there were full reporting of physical abuse, the 19 social workers charged with investigation and intervention into abuse cases would each have a caseload of 421 families per year. The social service system requires a major allocation of resources if it is to deal with more than a fraction of children at risk.

In addition, certain service programs such as comprehensive emergency services, 24-hour-a-day family shelters, 24-hour-a-day professional telephone referral services for families in crisis, drop-in day care, parenting education, homemaker services, and other programs which can ease the burden on families in crisis should be funded. One does not have to wait for all the research results to be in to realize that an effective Federal effort to prevent and treat child abuse must assist State and local agencies in providing the basic and necessary services to families in crisis.

In addition, just as Federal guidelines propose how State reporting laws should be drafted, the National Center on Child Abuse and Neglect can take the lead in drafting guidelines for services which should be available for children and families. Lastly, we recommend evaluation of service programs. One area where researchers and service providers can work hand-in-hand is the evaluation of innovative service programs to prevent and treat child abuse. A requirement of all federally funded demonstration grants and grants to support service should be that the programs be designed to enable rigorous and accurate assessment of the treatments. Funds should be made available to completely evaluate the programs. Current Federal efforts in this area do not appear to be designed to carry out this type of evaluation of funded service programs. The demonstration programs and the evaluations should be conducted in such a way that the programs could build in changes and test them after the evaluation had been conducted.

Senator RIEGLE. Thank you very much for your statement. We are going to make the full text of your statement a part of the record at the conclusion of your testimony, and we appreciate your summary.

Senator Cranston and I do have some questions. Even if this overlaps some things that you said earlier, please try to give sort of a brief summary in response to these questions, if that is possible.

The first question is as follows: What insight does your study offer with regard to the relationship of child abuse and neglect and other family problems? The thrust of your testimony is that in fact they are directly related, if I understood what you are saying.

Dr. GELLES. I would say it is directly related, although that is not the exclusive cause. One could probably explain perhaps 1 case in 10 of child abuse simply by knowing how much violence had been used on the mother. We find that violence in the family is closely related to family problems such as illness, juvenile delinquency, and so forth.

Senator RIEGLE. The second question is, does your study provide new data on the character of child abusers and their age, sex, social and economic background, and so forth?

Dr. GELLES. Our study on violence in the family, to the best of my knowledge after 7 years of research, is the only one of its kind that bases the research on a nationally representative sample. The incidence data I reported today is just the first fragments of data. We do have research data on social class, on personality factors, on income, education, age, sex and it does report new data, in that the data is based on a representative sample of the United States, rather than on clinical cases or on people who have been caught abusing their children.

Senator RIEGLE. The third question is, as researchers would you give us your views on the research, other than your own, which has been conducted under the authority of the Child Abuse Prevention and Treatment Act?

Dr. GELLES. Including my own?

Senator RIEGLE. No; setting yours aside.

Dr. GELLES. I have reviewed the 12 or 13 research proposals and the progress reports over the last 6 months and they yield a rather limited insight into the nature of child abuse. One of the most widespread problems is that almost all of the studies trying to explain the cause of child abuse uses officially designated cases of child abuse. When you do that, you can not determine if such factors as low social status cause people to abuse their children or make them more likely to get caught abusing their children. Our incidence data indicates for every child abuser that gets caught or every parent that gets caught in the act of abuse, there might be three or four that never come to public attention.

In Rhode Island, only 33 percent of the cases of suspected abuse actually come to public attention. The State agency delegated the task of dealing with abuse knows nothing about the other 67 percent.

Senator RIEGLE. Do you have any thoughts about how the act could be amended to change the nature or emphasis or the amount of research to try to deal with its deficiencies?

Dr. GELLES. In many ways the problem is administrative, unless the act can get into specifically saying we don't know enough about child abuse now, therefore let's not fund 12 big projects. Another problem with the research is there are too many projects with big budgets, half a million dollars, $300,000, whereas an effective research program begins with small scale exploratory studies to try to feel out the area. There aren't those studies going on. There aren't studies on definitions of abuse or studies on various types of families. I see a need for less concentration of resources on a few projects and a need to bring more excellent people into this area. I don't quite know how you draft legislation to do that. We are not bringing in excellence and new ideas and giving people the opportunity to do new and innovative types of research. When you fund only 12 projects, you kind of get the same old advice year in and year out.

Senator RIEGLE. Do you think there is a need for a system of peer review conducted by the National Institute of Health, or by an outside advisory body to assure the quality of research of this program?

Dr. GELLES. I see the need for rigorous peer review, as in the case of our research which was subjected to peer review by NIMH, which would, if it was in existence in the child abuse area, which would catch and identify problems such as studying only officially designated cases. There is peer review now. I don't believe it is quite as rigorous as the peer review in NIMH.

Senator RIEGLE. It is my understanding that you are familiar with the various efforts undertaken by the Federal center to respond to the requirement in the law for a study of the incidence of child abuse and neglect. Do these efforts by the American Humane Association, by various contractors, relate at all to the study that you conducted?

Dr. GELLES. There are a number of efforts underway. The American Humane Association, which operates a clearinghouse, really, only identifies caught cases in only 29 States and doesn't have a standard definition of what abuse is. It really yields no insight into what the incidence of child abuse might be.

The other project, which is a national incidence study, attempts to study child neglect, as well as abuse. I have been a consultant to that project since its beginning. That project is budgeted about 10 times higher than the budget for the research that I reported on today. I interpret this as meaning it costs $100,000 to study child abuse and $900,000 to study child neglect. I am not entirely sure it is worth that amount of money. I am not entirely sure the statistics which might be produced are worth that commitment of resources.

Senator RIEGLE. I appreciate the frankness of your answer.

To what extent or how big a factor do you think unemployment or chronic unemployment is through the chain of events that ultimately leads to child abuse?

Dr. GELLES. I have heard various estimates. A lot of people point to the fact that as the unemployment rate goes up so does the rate of child abuse: thus, unemployment causes child abuse. The problem in doing that is you don't know whether unemployed people actually abuse their children. Our preliminary research does indicate an association between unemployment, under employment and job frustration and violence in the family. The degree of association, how much of a casual factor it might be I couldn't say. I would say it does contribute to the abuse of women and the abuse of children.

Senator RIEGLE. Dr. Gelles, thank you for appearing. We appreciate your answers. We may want to give you some additional questions to respond to for the record. We appreciate your coming today and I appreciate your patience in waiting. I want to thank you for your contribution.

[The prepared statement of Dr. Gelles follows:]

Testimony Before the:
United States Subcommittee on Child and Human Development
Alan Cranston, Chairman

April 6, 1977
9:30 a.m.

VIOLENCE TOWARDS CHILDREN IN THE UNITED STATES

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Despite the considerable attention which has been focused on the issue of child abuse and neglect, and the significant and lengthy discussions concerning physical punishment of children, valid and reliable data on the incidence and/or prevalence of the use of violence and aggression on children by their parents are almost non-existent. Those data which are available offer varying estimates of child abuse and suffer from major conceptual, definitional, sampling and measurement problems. That the lack of any precise or valid estimate of the extent of child abuse was considered a serious enough gap in our knowledge about this phenomenon to mandate action,is evidenced in the call for a complete and full study and investigation of the national incidence of child abuse and neglect in the law which established the National Center on Child Abuse and Nelgect (PL 93-247).

My testimony today reports on preliminary data from a national survey (begun in 1976) of violence in the American Family. Our goal in undertaking this research effort (which was sponsored by the National Institute of Mental Health) was to provide scientifically reliable estimates of the incidence of violence used by parents on children, children on their parents, husbands and wives on each other, and between siblings. Our research is also designed to examine the factors associated with violence in families and to test theories which attempt to explain violence in family life.

PREVIOUS RESEARCH ON CHILD ABUSE

Previous research on the incidence of child abuse and neglect has failed to produce scientifically acceptable data for a number of reasons. First, many studies rely on official statistics on which to base their estimates. Official data, such as those gathered by the American Humane (Association) or Gil's survey of official reports (1970) are not amenable to estimating the national incidence of abuse for a number of reasons. First, in the case of the American Humane National Clearinghouse on Child Neglect and Abuse, data are not provided from all 50 states or from all localities in the participating states (in 1976 only 29 states participated in the Clearinghouse). Secondly, even if all states did participate in such an effort, uniform definitions of abuse are not used in all areas. Thus, each jurisdication defines abuse by their own "rule of thumb." Lastly, reported cases make up only a fraction of the children who are abused and neglected. Our research in Rhode Island found that only 33% of children suspected of being abused were actually reported to the state agency delegated the responsibility of investigating and servicing child abuse and neglect cases.

Other research efforts fail to adequately measure abuse and neglect due to vague and ambiguous definitions of child abuse. Child abuse has become a "political term" designed to draw attention to the problems of children. Such a term is often impossible to accurately define and measure.

Lastly, many research efforts use what could be loosely defined as"statistical alchemy." Numerous researchers and public figures have used local or regional estimates of child abuse and applied these rates to the national population. These types of statistical projections, such as using the rate of abuse in New York State to estimate the rate of abuse in the country,are impossible to validate or confirm. At best they can be regarded as guesses.

Estimates of child abuse and neglect range from projections of 10,000 children abused each year to 1 million. Even our knowledge about how many children die each year is limited. Estimates range from 700 per year (Fontana, 1973) to 5,000 (Hearings Before the Subcommittee on Children and Youth, 1973: 254). What is certain, is, as Cohen and Sussman state, "that the only conclusion which can be made fairly is that information indicating incidence of child abuse in the United States simply does not exist (1975: 4)."

It is evident that the conclusion made by Cohen and Sussman is the most accurate evaluation of the available data on the incidence of child abuse. Most of the projections can be regarded as simple "educated guesses." The information gleaned from official statistics must be qualified by the fact that they represent only "caught" cases of abuse which become cases through varied reporting and confirmation procedures. In addition, information on "child abuse" is difficult to interpret because the term "child abuse" is as much a political concept, designed to draw attention to a social problem, as it is a scientific concept which can be used to measure a specific phenomenon. In other words, child abuse can be broadly and loosely defined in order to magnify concern about this social problem. While some social scientists use the term to cover a wide spectrum of phenomenon which hinder the proper development of a child's potential (see for example: Gil, 1975), others use the term to focus attention on the specific case of severely physically injured children (see for example: Kempe et. al., 1962, and the discussion of the "battered baby syndrome").

The lack of valid and reliable data on the incidence of child abuse in the United States led to the inclusion of a clause in the Child Abuse Prevention and Treatment Act of 1974 (PL-93-237) calling for a full and complete study on the incidence of child abuse and neglect. Such a study has already been contracted by the National Center of Child Abuse and Neglect. As an indication of the major problems which arise when one tries to measure the abuse and neglect of children, the contracted study has moved into the second quarter of its two year existence and no decisions have been made on appropriate definitions of abuse or what research design should be employed in the study.

A Note on Trend Data. It should be pointed out that the problems involved in estimating the incidence of child abuse make the task of interpreting trend data almost hopeless. First, it is impossible to determine if rates of reported abuse are rising due to an actual increase in the true rate of abuse or due to increased sensitivity on the part of professionals who see children and families. Secondly, the constant change in the definition of abuse and the constant revisions of state child abuse and neglect laws, tend to broaden the definition of child abuse. This means that more families and children are vulnerable to being identified as abusers and abused.

The Need for a Study of Parental Violence

It was after evaluating the available evidence on the extent of force and violence between parents and children that we embarked on a national study of parental and family violence. While physical punishment of children appeared to be almost a universal aspect of parent-child relations, and while child abuse seemed to be a major social problem, we know very little about the modes and patterns of violence towards children in our society. We know almost nothing about the kinds of force and violence children experience. Are mothers more likely to hit their children then fathers? Who employs the most serious forms of violence? Which age group is most vulnerable to being spanked, slapped, hit with a fist, or "beat up" by their parents? Although answers to these questions will not completely fill in the gaps in our knowledge about child abuse, we see the information we generate in this study as providing an important insight into the extent of force and violence children experience and how many children there are who are vulnerable to injury from serious violence.

METHODS[1]

One of the most difficult techniques of studying the extent of parental violence is to employ a household interview which involves the self-reporting of violent acts. Although this technique is difficult and creates the problem of underreporting, we felt that because of the shortcomings of previous research on child abuse, this was the only viable research design which we could employ to assess the extent and causes of intra-family violence.

Sample and Procedures

The Response Analysis[2] national probability sample was used for this study. A national sample of 103 primary areas (counties, or groups of counties) stratified by geographic region, type of community, and other population characteristics was generated. Within these primary areas, 300 interviewing locations (census districts or block groups) were selected. Each location was divided into 10 to 25 housing units by the trained interviewers. Sample segments from each interviewing location were selected and the last step involved randomly selecting an eligible person to be interviewed in each designated household.

Eligible families consisted of a couple who identified themselves as married or being a "couple" (Man and woman living together in a conjugal unit). A random procedure was used so that the sample would be approximately half male and half female.

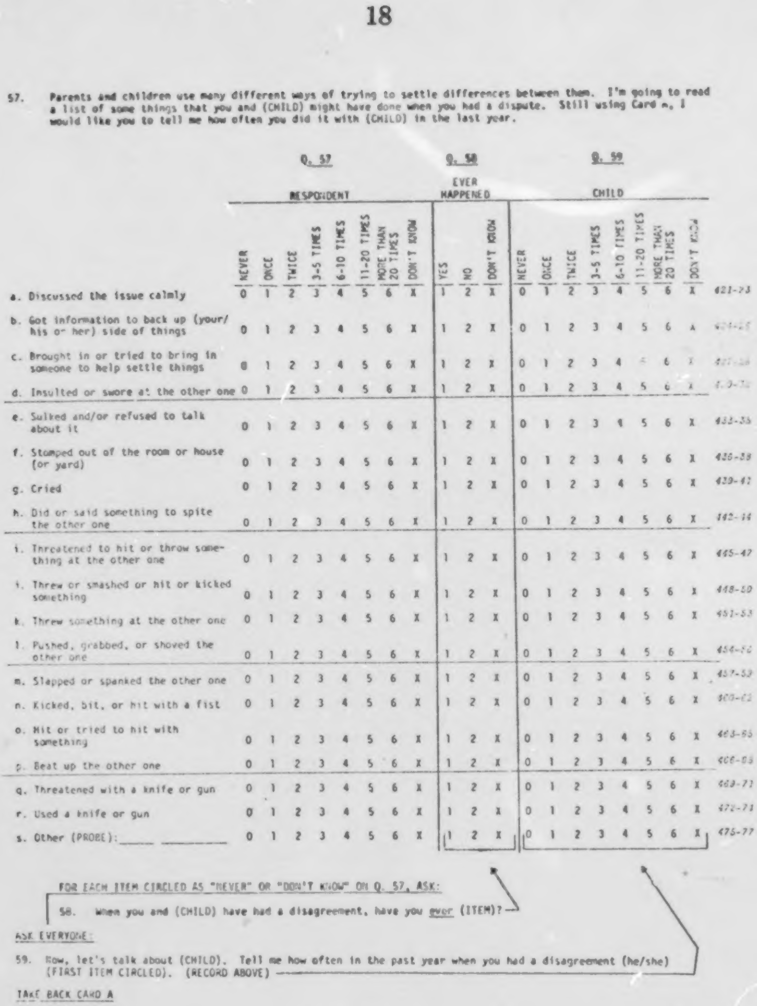
The final national probability sample produced 2,143 completed interviews.[3] Interviews were conducted with 960 men and 1,183 women. In each family where there was at least one child living at home between the ages of 3 and 17, a "referent child" was selected using a random procedure. Of the 2,143 families interviewed, 1,146 had children between the ages of 3 and 17 living at home. Our data on parent to child violence are based on the analysis of these 1,146 parent-child relationships.

The interviews were conducted between January and April, 1976. The interview protocol was designed to take approximately 60 minutes to complete. The questions on parent to child violence were one part of an extensive protocol designed to measure the extent of family violence and the factors associated with violence between family members.

The final sample of 2,143 families appears to be extremely representative in terms of major demographic attributes of American families.

Violence: Defined and Operationalized

For the purposes of this study, violence is nominally defined as "an act carried out with intention of, or perceived intention of, physically injuring another person." The "physical hurt" can range from slight pain, as in a slap, to murder. The basis for the "intent to hurt" may range from a concern for a child's safety (as when a child is spanked for going into the street) to hostility so intense that the death of the other is desired.



18

57. Parents and children use many different ways of trying to settle differences between them. I'm going to read a list of some things that you and (CHILD) might have done when you had a dispute. Still using Card A, I would like you to tell me how often you did it with (CHILD) in the last year.

	Q. 57								Q. 58			Q. 59								
	RESPONDENT								EVER HAPPENED			CHILD								
	NEVER	ONCE	TWICE	3-5 TIMES	6-10 TIMES	11-20 TIMES	MORE THAN 20 TIMES	DON'T KNOW	YES	NO	DON'T KNOW	NEVER	ONCE	TWICE	3-5 TIMES	6-10 TIMES	11-20 TIMES	MORE THAN 20 TIMES	DON'T KNOW	
a. Discussed the issue calmly	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	421-23
b. Got information to back up (your/his or her) side of things	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	424-26
c. Brought in or tried to bring in someone to help settle things	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	427-29
d. Insulted or swore at the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	430-32
e. Sulked and/or refused to talk about it	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	433-35
f. Stomped out of the room or house (or yard)	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	436-38
g. Cried	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	439-41
h. Did or said something to spite the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	442-44
i. Threatened to hit or throw something at the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	445-47
j. Threw or smashed or hit or kicked something	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	448-50
k. Threw something at the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	451-53
l. Pushed, grabbed, or shoved the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	454-56
m. Slapped or spanked the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	457-59
n. Kicked, bit, or hit with a fist	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	460-62
o. Hit or tried to hit with something	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	463-65
p. Beat up the other one	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	466-68
q. Threatened with a knife or gun	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	469-71
r. Used a knife or gun	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	472-74
s. Other (PROBE):_____ _________	0	1	2	3	4	5	6	X	1	2	X	0	1	2	3	4	5	6	X	475-77

FOR EACH ITEM CIRCLED AS "NEVER" OR "DON'T KNOW" ON Q. 57, ASK:

58. When you and (CHILD) have had a disagreement, have you *ever* (ITEM)?

ASK EVERYONE:

59. Now, let's talk about (CHILD). Tell me how often in the past year when you had a disagreement (he/she) (FIRST ITEM CIRCLED). (RECORD ABOVE)

TAKE BACK CARD A

FIGURE 1

Violence was operationalized in the national study of family violence through the use of a scale titled the "Conflict Resolution Technique- (CRT)." This technique was first developed at the University of New Hampshire in 1971 and has been used and modified extensively over the past five years in numerous studies of family violence. The Conflict Resolution Technique Scales were designed to measure intrafamily conflict in the sense of the means used to resolve conflicts of interest (Straus, 1976:4). The Conflict Resolution Technique contains three groups of conflict resolution items: (1) the use of rational discussion and argument; (2) the use of verbal and non-verbal expressions of hostility-- such as acts which symbolically hurt the other or threats to hurt the other; and, (3) the use of physical force or violence as a means of resolving the conflict. The final scale contains 18 items, 8 of which involve the use of force or violence.

Figure 1 About Here

The administration of the Conflict Resolution Technique involves presenting the subjects with the list of the 18 items and asking them to indicate what they (the subjects) did when they had a disagreement with the referent child in the past year and in the course of their relationship.

Reliability and Validity. The reliability and validity of the Conflict Resolution Technique has been assessed over the five year period of its development and modification. Pretests on more than 300 college students indicate that the indices have an adequate level of internal consistency reliability (Straus, 1976: 11). While there are no definite tests of the validity of the CRT scales, evidence of "concurrent validity" exists (Straus, 1976: 11). In addition, evidence of "construct validity" exists in that data compiled in the pretests of the scale are in accord with previous empirical findings and theories (Straus, 1976: 13).

Advantages and Disadvantages of the Violence Scale. An advantage of the violence scale, aside from previous evidence of its reliability, "concurrent" validity, and "construct" validity, is that the mode of administration increased the likelihood of the interviewer establishing rapport with the subject. The force and violence items came at the end of the list of conflict resolution items. Presumably, this enhanced the likelihood that the subject would become committed to the interview and continue answering questions. Our analysis of the responses to the items indicates that there was no noticable drop in the completion rate of items as the list moved from the rational scale questions to the most violent modes of conflict resolution.

Two disadvantages of the scale are: (1) it focuses on conflict situations and does not allow for the measurement of the use of violence in situations where there was no "conflict of interest." Secondly, the scale deals with the commission of acts only. We have no idea of what the consequences of those acts were. Thus, we have only a limited basis of projecting these statistics to the extent of the phenomenon "child abuse", since child abuse normally is thought to be an act which has some injurious consequences for a child. While we may learn that a parent used a gun or a knife, and we can presume that this has negative consequences for the child, even if he or she was not injured; we do not know what the actual consequences were.

RESULTS

We proposed that "ordinary" physical punishment and "child abuse" are but two ends of a single continuum of violence towards children. In between are millions of parents whose use of physical force goes beyond mild punishment, but which, for various reasons does not get identified and labeled as child abuse.

Sixty-three percent of the respondents who had children between the ages of 3 and 17 living at home mentioned at least one violent episode during the survey year.[4] The proportion of our sample reporting at least one violent occurrence in the course of raising the child was 73 percent.

As expected, the milder forms of violence were more common. Slaps or spankings were mentioned by 58 percent of the respondents as having occurred in the previous year and by 71 percent of the parents as having ever taken place. Forty-one percent of the parents admitted pushing or shoving the referent child in 1975; while forty-six percent said pushes or shoves had ever occurred. Hitting with something was reported by

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Table 1 About Here

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13 percent of the parents for the last year and by 20 percent for the duration of their raising the referent child. Throwing an object was less common--approximately 5 percent of the parents did this in the survey year while more than 9 percent had ever thrown something at their referent child.

The more dangerous types of violence were the least frequent. However, extrapolating the data to the population of children 3 to 17 years of age living with both parents produces an astoundingly large number of children who were kicked, bit, punched, beat up, threatened with a gun or a knife, or had a gun or a knife actually used on them. First, looking at the number of parents who reported each type of violence, approximately 3 percent of the parents reported kicking, biting, or hitting the referent child with a fist in 1975; while nearly 8 percent stated that these acts had occurred at some point in the raising of the child. Slightly more than 1 percent of the respondents reported "beating up" the randomly selected referent child in the last year and 4 percent stated that they had ever done this.[5] One-tenth of 1 percent, or one in a thousand parents admitted to threatening their child with a gun or a knife in 1975, while nearly 3 parents in 100 said they had ever threatened their child with such weapons. The same statistics were found for parents admitting actually using a gun or a knife--

TABLE 1

TYPES OF PARENT TO CHILD VIOLENCE

	OCCURRED IN PAST YEAR				PERCENT EVER
	Once	Twice	More Than Twice	Total	OCCURRED
Threw Something (n=1142)	1.3%	1.8%	2.3%	5.4%	9.6%
Pushed, Grabbed, or Shoved (n=1146)	4.3%	9.0%	27.2%	40.5%	46.4%
Slapped or Spanked (n=1145)	5.2%	9.4%	43.6%	58.2%	71.0%
Kicked, Bit, or Hit with Fist (n=1143)	.7%	.8%	1.7%	3.2%	7.7%
Hit with Something (n=1145)	1.0%	2.6%	9.8%	13.4%	20.0%
Beat Up (n=1140)	.4%	.3%	.6%	1.3%	4.2%
Threatened with Knife or Gun (n=1144)	.1%	0%	0%	.1%	2.8%
Used a Knife or Gun (n=1142)	.1%	0%	0%	.1%	2.9%

.1 percent for the year, almost 3 percent ever.[6]

One can extrapolate these frequencies to estimate how many children were victims of these serious modes of violence in 1975 and how many ever faced these types of violence.[7] There were nearly 46 million children between the ages of 3 and 17 years old who lived with both parents in 1975 (Bureau of the Census, 1975). Of these children between 3.2 and 3.9 million have ever been kicked, bit,or punched; while between 1.2 and 1.7 million were kicked, bit, or punched in 1975. Between 1.6 and 2.2 million children have been "beat up" while growing up, and between 460,000 and 3/4 of a million 3 to 17 year olds were "beat up" in 1975. Lastly, our data means that between 1 and 1.4 million American children, between the ages of 3 and 17 have ever had their parents use a gun or a knife on them. Our figures do not allow for a reliable extrapolation of how many children faced parents using guns and knives in 1975, but our estimate would be something close to 46,000 children (based on an incidence of 1 in 1,000 children).

An examination of the data on violence used on children in 1975 indicates that violence typically is a phenomenon that is a pattern of parent-child relations rather than a one or two time event. Only in the case of using a gun or knife was the violent episode likely to be a one-time affair. While it is generally accepted that slaps, spankings, and shoves are frequently used techniques of child rearing, we find that even bites, kicks, punches, and using objects to hit children occur frequently in the families where they are employed.

Chilren at Risk

As we stated earlier, our examination of violent acts without information on the consequences of those acts prevents us from accurately estimating how many children incurred physical harm from violence during any one year. Our problem is compounded by the fact that we rely on the subject's own definition of what is meant by "beating up" a child. In addition, we do not know what objects were used to hit the child (a pipe or a paddle), and, we do not know how the guns or knives were deployed. Nevertheless, we felt it was important to generate an estimate of chilren-at-risk. We chose to compile an "at-risk" index which combined the items we felt produced the highest probability of injuring or damaging the child (kicked, bit, or hit with a fist; hit with something; beat up; threatented with a knife or a gun; used a knife or a gun). Using this index, we found that 3.6 percent of the parents admitted to using at least one of these modes of violence at least once in 1975. Assuming the acts we indexed have a high potential of causing harm to the intended victim, between 1.4 million to 1.9 million children were vulnerable to physical injury from violence in 1975.

A Note on the Incidence Data and Extrapolations

The data on the incidence of physical violence between parents and children and the extrapolations which produced estimates of the number of children who experienced violence and who are at risk of physical injury ought to be considered low estimates of violence towards children. These figures represent a low estimate of violence for a number of reasons. First, we are dealing with self-reports of violence. Although the subjects responding that they spanked or slapped their children may be a good estimate of how many people actually carried out these acts, we believe that the desire to give socially desired responses caused many people to underreport the more serious modes of violence. If one subject in a thousand answered that they used a gun or knife, it might be reasonable to assume that at least another one in a thousand used these weapons and did not admit to it in the interview. Secondly, we interviewed only "intact" families where both adult males and females were in the household. Thus, our data are representative of two parent families. If, as some believe, parental violence is more common in single parent families, then our data underestimate the number of children experiencing potentially dangerous acts by their parents. Lastly, our lower than expected response rate might mean that some high violent families may have refused to be interviewed. If this is the case (and we as yet do not know if it is), our incidence statistics might again be low estimates of violence towards children.

As a result of the sampling frame used and the methodological problems involved in using self-reports of violence, we see our statistics, although they may seem high to some, as being quite conservative and low estimates of the true level of violence towards children in the United States.

Other Findings

Our analysis to date also indicates that mothers are slightly more likely to use violence on their children than fathers; although, mothers and fathers were equally likely to use serious and dangerous forms of violence on their children. Sons were the most common victims of parental violence, including serious attacks. Lastly, we found that younger children were the most frequent victims. However, the data indicate that older children were vulnerable to more serious attacks and that violence does not stop when a child goes to school--more than 1/3 of the children 10 to 14 were struck by their parents in the survey year.

DISCUSSION

The data on the incidence of parent to child violence only begin to scratch the surface of this very important topic. Our results indicate that violence towards children is an extensive and patterened phenomenon in parent-child relations which involves various types of violent acts. In addition, we see that mothers are the most likely users of violence while sons and younger children are the more common victims.

A number of controversial points arise form our presentation. First, disagreement over our nominal and operational definitions of violence may lead some to disagree with our conclusion that violence is widespread in families. If someone views slaps and spankings as acceptable punishment, then they might dispute our statistics as being based on a too broadly constructed definition of violence. Although we believe there are many salient reasons for considering spankings and slaps violent, we would counter this argument by pointing to the statistics for beating up children or using a gun or a knife on a child. If one in 1,000 children had guns or knives used on them in school, we would consider that a problem of epidemic proportions. The fact that these acts occur in the home tends to lessen concern about the impact and consequences. However, the impact and consequences are potentially dramatic, since the child is experiencing violence from those who claim love and affection for him.

A second point which will be raised about our findings is the question of bias and whether our respondents actually told the truth. We have spent seven years of careful testing and development of the instruments used in this study. Ultimately, however, we can never know the actual validity of our findings or whether our subjects "told the truth." Our assessment of the biases and problems of studying family violence is that the major bias is likely to be one of underreporting. We doubt that many subjects will report beating up their children or using a gun or a knife on them if they did not. Thus, our statistics are probably underestimates of the true level of parent-child violence in the United States. If one considers the possibility that for every subject who admitted using a knife or a gun, that an additional subject used these weapons but did not admit it, then our estimate of risk could be doubled to produce a true estimate of risk of physical violence.

Another issue which we considered after examining our data, and an issue which we will pursue in later analyses, is the fact that people actually admitted using severe and dangerous forms of physical violence.

Our tentative explanation of this is than many of our subjects did not consider kicking, biting, punching, beating up, shooting, or stabbing their children deviant. In other words, they may have admitted to these acts because they felt they were acceptable or tolerable ways of bringing up children. Thus, it may be that one major factor which produces the high level of parent-child violence we have found is the normative acceptability of hitting one's children.

Despite the methodological problems we encountered, the fact that this is the first survey of parent-to-child violence based on a true cross-section of American families means that the data presented here are closer to describing the real situation of violence towards children in America then anything available up until now.

IMPLICATIONS AND RECOMMENDATIONS

1. A continued emphasis on research into the causes of child abuse and a coordination of Federal research efforts in this area and in the area of family violence.

The research on which my testimony today is based and the research which we hope will yield furthur insights into the causes of family violence is the product of a seven year research effort involving three investigators, three Universities, and numerous federally funded projects. Our knowledge base in the area of child abuse is limited because the research which is needed to build such a base has only recently been started. It would be unrealistic to think that three years is a sufficient amount of time to gather and analyze data which would help provide the key to understanding the nature and generative sources of child abuse. It took us seven years to get to a point where we felt we could begin to measure the incidence and causes of family violence.

2. Recommended Research Priorities
   A. More research projects with smaller grant awards to stimulate innovative exploratory research.
   B. Less reliance on research which uses officially designated cases of abuse. More use of probability samples and national samples which can be used to assess incidence, prevalences, and causes of various types of abusive behavior.
   C. Research on the official responses to child abuse and family violence which focuses on and evaluates the effectiveness of social service, police, and community responses to children at risk.
   D. Funding of longitudinal studies which can assess change and engange in sophisticated causal analysis of factors which operate outside and within families which may cause abuse.
   E. A more adequate program of soliciting grant applications and reviewing grant proposals which provides the research community with adequate time to prepare a proposal and provides for the highest quality review of the proposals submitted.
3. Consider the entire scope of violence in the family

Focusing only on the topic of child abuse tends to block out the perception of the family as a social system. Our research indicates that nearly 2 million American couples have used a lethal weapon on one another during their marriage, while more than 2 million couples report a beating between a husband and a wife. In addition, 2 million children have grown up using a gun or a knife on a sibling. We find these types of violence are highly correlated. Thus, wives who are abused by their husbands tend to turn their violence on their children, who in turn, use violence on their siblings. We are not proposing that this pattern of violence is the single cause of child abuse--we already realize that child abuse arises from multiple causes. However, we see a need for effective research and service programs which examine the entire range of family violence and the interrelationship of various types of violence in the home.

4. Provide funds and assistance in basic service areas.

As researchers we are sensitive to the cry that money should be spent to solve problems rather than to study them. It would seem that these two enterprises ought not be mutually exclusive. While we do not yet know what causes child abuse, and while more research is necessary before we can adequately treat and prevent abuse, we know now that certain service programs are in need of major resources. For instance, if our data are accurate, then in Rhode Island alone, if there were full reporting of physical abuse, the 19 social workers charged with investigation and intervention into abuse cases would each have a case load of 421 families per year. The social service system requires a major allocation of resources if it is to deal with more than a fraction of children at risk. In addition, certain service programs such as Comprehensive Emergency Services, 24 hour a day family shelters, 24 hour a day professional telephone referral services for families in crisis, drop in day care, parenting education, homemaker services, and other programs which can ease the burden on families in crisis should be funded. One does not have to wait for all the research results to be in to realize that an effective Federal effort to prevent and treat child abuse must assist state and local agencies in providing the basic and necessary services to families in crisis. In addition, just as Federal guidelines propose how state reporting laws should be drafted, the National Center on Child Abuse and Neglect can take the lead in drafting guidelines for services which should be available for children and families.

5. Evaluate service programs.

One area where researchers and service providers can work hand-in-hand is in the evaluation of innovative service programs to prevent and treat child abuse. A requirement of all federally funded demonstration grants and grants to support service should be that the programs be designed to enable rigorous and accurate assessment of the treatments. Funds should be made available to completely evaluate the programs. Current federal efforts in this area do not appear to be designed to carry out this type of evaluation of funded service programs. The demonstration programs and the evaluations should be conducted in such a way that the programs could build in changes and test them after the evaluation had been conducted.

FOOTNOTES

1. A complete methodological report will appear in VIOLENCE IN THE AMERICAN FAMILY.

2. Response Analysis Corporation, of Princeton, New Jersey, was contracted to carry out the household survey.

3. The completion rate for the entire sample was 65%. This rate is somewhat lower than we expected despite intensive efforts on the part of the contractor to increase the completion rate through call backs, letters, and monetary incentives. The completion rate varies from a low of 60.0% for metropolitan areas to a high of 72.3% for nonmetropolitan areas. Due to differential response rates by sex and location, the extrapolations and incidence estimates presented in this paper will later be modified using a weighting procedure. Thus, the results we present will be slightly altered in the final presentation of the data.

4. Since the field work began in January, 1976 and since we asked for information concerning the "previous year", the survey year can be thought to be 1975.

5. We have no precise or standard definition of "beating up." "Beating up" was measured by asking the subjects if they ever "beat up" their child. Thus, the meaning of this term varied from subject to subject. Nevertheless, the term does connote a serious level of violence.

6. Again, we do not know exactly what is meant by "using a gun or a knife." In the case of the knife it could mean the parent threw the knife at the child or actually stabbed or attempted to stab the child. The gun could have been fired without the child being wounded. However, the fact is that the parents admitted employing the weapon, not just using it as a threat.

7. We have extrapolated to number of children rather than number of families or parents because our data collection involved the investigation of parental use of violence on a referent child. Since we focused on only one of a possible number of parent-child relations in the family, we do not know the full extent of the respondent's use of violence on all the children, nor do we know the total extent of parent to child violence in the family. In addition, we extrapolated to children in the population because the procedures used to select families and referent children have presumably yielded a random sample of children between 3 and 17 years old who lived with both parents in 1975.

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Senator RIEGLE. Now we are going to take about a 5 minute recess. I have to attend to one matter. Our next panel will be Dr. Kempe, Dr. Newberger, Dr. Zigler, and Commissioner Parry. There will be a 5 minute recess, so if anybody wants, you can sort of stretch your legs and get ready. We will start in approximately 5 minutes.

[Short recess taken.]

Senator RIEGLE. I thank you for your patience. It is the nature of this institution that sometimes you just can't move things quite the way you would like to move them, but we are delighted to have the four of you here as witnesses.

Dr. Kempe, will you be starting?

STATEMENT OF C. HENRY KEMPE, PH. D., PROFESSOR OF PEDIATRICS AND MICROBIOLOGY AT THE UNIVERSITY OF DENVER AND DIRECTOR OF THE NATIONAL CENTER FOR THE PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT, DENVER, COLO.

Dr. KEMPE. Senator, I am Dr. C. Henry Kempe, professor of pediatrics and microbiology at the University of Denver and director of the National Center for the Prevention and Treatment of Child Abuse and Neglect.

I have worked in child abuse and neglect for some 20 years and I got into it primarily through my dissatisfaction with the role physicians and nurses played in inadequate and late diagnosing of child abuse and neglect, and then with dissatisfaction with the system in dealing with the problems of family diagnosis, and dissatisfaction with the treatment of child abuse, which was limited to only one case worker, a social worker, who worked with the mother, with no regard to the father or child or other children in the family.

Over the last 20 years I have dealt with 4,000 families who came in through the health care system. With my colleague, Dr. Helfer, we have produced four books as a result of this study, which I have submitted to the committee.

My testimony is somewhat limited because Dr. Zigler and Dr. Newberger will follow me and I associate myself with their comments, and Mr. Brian Frasier, of Chicago, who will be on tomorrow and who has worked with me for many years.

I will therefore limit myself to those areas not covered by them. In my testimony, which is under this yellow sheet, I will touch on some technical and refining language for minor changes in the bill that might be possible in case a short extension is sought, and then I will make suggestions for more extensive changes if Congress decides to look at the whole bill.

The focus of the act we believe should shift to the next set of tasks which would help children. One, programs for prediction and prevention of child abuse as exemplified by the counselor or health visitor, for example; a paper in that regard is enclosed with the testimony.

I will submit to the committee three recent research studies, one of which touches on the effectiveness of prediction and prevention of child abuse at the time of the child's actual birth in the hospital and in the first 48 hours of the family life in the hospital after the child is born. This seems to me much more helpful, a more helpful approach in many ways, than trying to patch up children already hurt.

We hope to deal in the next phase of the Child Abuse Act with the better evaluation and better diagnostic methods and therapy programs of great variety, which have been referred to earlier. The greater availability of public and private diagnostic and therapy programs will make for community effort and will bring community cooperation in such programs to bear, and finally, will make for better research efforts.

The Child Abuse Act should permit Federal funding to help States reach the standards we hope to see attained. For example, funding could be based on submission of an adequate plan for improvement of services, rather than by applying only the direct language of the bill as written.

Although individual regional resource projects have created important new programs for the management of child abuse and neglect, the "demonstration" label of the regional resource projects will lead to dropping of Federal support within 1 year.

Two alternatives for meeting my concern are suggested. The minimal version reduces the emphasis on incidence studies, greatly eases State eligibility fund funding, makes permanent the regional resource centers while increasing standards for regional resource centers, increases the proportion of total funding to be allocated to States, and creates a non-Federal advisory board as initially intended by the Congress under this act, but subverted by the previous administration into an inhouse advisory board, to take the place of the current, narrowly constituted interagency committee. Regional resource centers should be increasingly used to coordinate programs and offer high level consultation both to States and the National Center on Child Abuse and Neglect here in Washington. The non-Federal advisory board would help assure that the NCCAN programs here would represent the best thinking about the problems of child abuse and neglect.

The more complete revision restricts funding of programs to develop new training materials, since we feel we are totally surfeited with these, but would permit continued training and purchase of completed training programs on hand. This second alternative permits new types of funding for State activities, provides a formula for State funding moved completely away from using reporting acts as a test for eligibility, and is drafted to reduce waste at the Federal and State level.

In summary then, we hope to reach compliance in the remaining States forthwith because in fact they do just about equally as good a job, regardless of the language of the State law. Second: We believe the regional resource center should be a national resource concept, used increasingly by the central office as a professional high-quality advisory board. Finally, we believe that the national advisory council, essentially, must be put in place quickly, administratively or by law so that proper direction can be given to the administration of these activities.

I would close by saying the prevention of child abuse is, to me, one of the most exciting things on the horizon. We spent 20 years trying to understand child abuse better. I think we know a good deal, but there is much yet to know. The presence of three predictive studies, the three across the country, suggests that it is no problem knowing what family will be in need of this service from the very start, when they are in fact available to us and we to them, and then essentially not available to each other until the child reaches school age. We have in this country a great hiatus from the time the child is born to the time the child must enter school. In this respect we differ from all western nations, where the child is in the society and gets health care from the system from day one.

It seems to me there is an opportunity here to make a major impact on child abuse and, beyond that, on helping the family get a good start by not only helping this particular child, but the other children in the family, as well. I thought I would take finally a minute or two to state that a great deal of good has happened since the beginning of the public law; it has brought forward in a very quick way a message from the Federal Government to the States and to the 3,300 county welfare departments, each of which is almost a State in its own terms in child protective services. It has given them some idea about the melding of private and public agencies in child protection. It is suggested for the first time that we should have an open system in which the citizens at large have a stake in the welfare of the family and the child. It has developed the concept of an interdisciplinary effort—doctors, nurses, social workers, psychiatrists, police, judges, and the citizens at large working to help families in trouble. I think it has broadened the concept of protective social service work from being a single discipline field, absolutely closed tight, to one which, in effect, is open and enlists the best efforts of the society at large in supporting the welfare departments in their struggle to get sufficient programs started.

I think one should realize that for 50 years they have struggled on their own and they have very little help from us doctors and the public at large. They were in trouble only when something went badly wrong with the cases they handled. They are the only public resource, to my knowledge, that has spread itself thin to meet the demands of the caseload. The police don't; no other public resource does adjust its capacity to function with the manpower in hand, with the exception of protective services. Social workers all over the country, whether they have 80 cases or 20 or 300 will try to adjust themselves to the requirements of the caseload. This is quite wrong and we have learned, I think, finally through our efforts in broadening the field, opening up the system, letting the citizens know what a reasonable caseload is in child abuse service—which is 20 to 22—that if they are willing to put out money they can buy this much service for this much money and that nowadays just giving social workers, caseworkers, an aide to mothers, is no longer considered adequate.

We know now no abuse has ever occurred in the last 9 years in our programs when services were broadly made available; these included not just caseworkers, but the use of lay therapists, who are case aides, to supplement social workers, but who cost much less and lengthen and strengthen and extend the social worker's hands. Also, crisis nurseries for children, the use of small group homes for children as an alternative to automatic foster placement and separation from parents, the use of therapeutic nursery schools or supplementary nursery schools for children who have been abused, efforts to provide intensive help to families who can be helped and at the same time recognize about 10 percent of our patients cannot be helped with their particular child. In other words, it is important to realize some people cannot be helped in the matter of child abuse and that the termination of parenting arises and adoption of the child forthwith is to the best interests of the child and parents as well. We must come to the realization that not all children can be kept in a given family, that not all families can be cured or helped. These programs require the initial effort between disciplines to succeed.

Public Law 93–247 has given that message by the language of the bill to virtually every 1 of the 3,300 county welfare departments. And, finally, I would like to say a word about the spinoff of this bill. For every request granted, I am sure that there are 20 to 100 that could not be granted for fiscal reasons. I am impressed in going around the country to find that many people who did not get funded still went ahead and made some effort in the right direction. This is hard to put in terms of dollars, but I am impressed that the effort was, in effect, much greater in this regard than we saw in the actual funded programs, and that may be one of the most important aspects of this bill.

Senator RIEGLE. Thank you very much. We are especially pleased to have you journey here and share with us your insights based on 20 years of work and leadership in the area.

I might just ask you one thing before we go to the next speaker. I am very interested in what you were saying about prevention and about what could be done from the time the child is born and within 48 hours afterward. Could you elaborate a little more on what we now know or what we have learned in that respect and the meaning of it?

Dr. KEMPE. In summary, in our own study, which practices prospective, families whose reaction to the birth of the baby at the time of delivery in the labor room was negative to the child, right at that moment, for the first hour of contact with the child and the father and mother, and I might add 90 percent of our fathers attend deliveries, we have a form that the nurses use that says how does the mother look, what does the mother say, what does the mother do—look, say, do. It couldn't be any simpler in terms of nursing observation. Most parents look happy, say is it a boy, and kiss the baby or hug the baby. Occasionally in our case a significant number of parents have negative verbalization about the child, indicate no interest as to the sex of the child, will not make eye contact with the child, which most people automatically do when you give them the baby. The nursery upstairs is notified of the problem at hand and they will assist the mother, encourage the mother, observe the behavior of the mother and child and if it continues to be negative, this information is an absolute necessity for the future well-being of the child and to be provided to future nursing service. We have shown in the prospective study that this in no way interferes with the process of things and if we did not do something substantial in terms of treatment of these families that one in five of the children would be in hospitals as abused children in the next 2 years—one in five—20 percent, so this is a highly predictive system. We didn't change the parenting, but we certainly stopped some abuse, and the money saved for these five cases in the State of Colorado alone would have been $1 million.

Those five injuries, one child was permanently blinded and permanently brain damaged, which cost the State $700,000; one was severely burned, which required 6 months' hospitalization, at a cost of $700,000. And there were two major fractures. The total cost to the State of Colorado was $1 million. I point this out because the cost of the outreach service in the other group that prevented all of those injuries was very cheap. That cost them $12,000. So here was $12,000 as a cost of preventing versus $1 million in the other instance.

Senator RIEGLE. That is a very powerful example.

Who wishes to go next?

STATEMENT OF EDWARD ZIGLER, PH. D., RESEARCH ANALYST, YALE UNIVERSITY, NEW HAVEN, CONN.

Dr. ZIGLER. It is an honor for me to speak next, Senator Riegle. My name is Edward Zigler and I am from Yale University. I have been working in the area of deprived and abused children for a period of about 20 years. In addition, I am very much interested in the construction and implementation of social policy and have served in Washington as first Director of the Office of Child Development and also as a Chief of the U.S. Children's Bureau.

I must confess at the outset that I am pessimistic and ambivalent about your bill. I wrote a very strong issue analysis of the child abuse problem in this country, and sent it to the staff members of this committee. My pessimism is probably indicated in the title, which is "Controlling Child Abuse in America; An Effort Doomed to Failure."

Now let me very quickly give you an overview of my specific concerns about this bill, discussed at some length in my paper.

First a couple of rhetorical questions are in order. Do I think that this act should be extended?

Yes, I do.

Its primary benefit, in my opinion, lies in its calling attention to the problem of child abuse. This is valuable since a society will not attempt to solve a problem until there is a real sense that a problem exists.

My second question: Do I think that this bill will have a sizable impact on the incidence of child abuse?

No; I do not.

Now, since we certainly do not wish to do any harm, I also had to look at this bill and ask myself the question, does this bill present any dangers to the country? My answer, unfortunately, is yes, it presents two dangers: First, it presents the danger of tokenism. By that I mean, as my colleague has already stated, we know how to impact families and reduce child abuse, but it costs a lot of money. It is not a lack of knowledge that stops us, but a lack of commitment. It is too easy, as Professor Gelles says, to play the numbers game with the incidence of child abuse, and we need the kind of data he is providing. I am quite content to use the estimate of 1 million cases since that is about as good as we have. But when I take 1 million and divide it into a bill with funds in the neighborhood of $20 million, that is about $20.00 per case. Anyone who knows what services are all about will immediately tell you that that is obviously an inadequate sum.

Now there is a second danger in this bill and one that has yet to receive the recognition in Congress and among experts on child abuse that it deserves. The bill's emphasis on reporting child abuse, in my opinion, may unleash a bureaucratic monster in which many innocent people will be placed on lists. There is indeed already a phenomenon in our Nation where people are going around taking names. My feeling is that these lists represent a threat to the civil rights of the citizens of this Nation. I have looked closely at the situation in the State of Massachusetts and I am very troubled by what I see. In fact, child abuse is the only instance I know of in which the individual is considered guilty until he is proven innocent. While I have the highest respect for Dr. Kempe, I cannot help but be troubled to hear that we are going to start examining the eye contact between a new parent and a child and decide at that point in time which parents are potential child abusers.

This is what is going on in Massachusetts. The list now includes so-called potential child abusers. If we continue down this path, I guarantee you that there is no end to it because it will turn out that we are all potential child abusers and deserve to be on that list.

I therefore ask this Committee to do all it can to protect our citizens from the excesses in zeal that have now come to characterize certain state laws concerning the reporting of child abuse.

I would recommend the construction of a model State law on child abuse reporting and a model law that has been looked at and approved by the American Civil Liberties Union.

Now, what should be done? It is not my style or my character to be so negative and pessimistic. I think there is always something that can be done constructively and we must look for those efforts, so I have some very specific suggestions. First, I can underline with great enthusiasm all that Professor Gelles has told you this morning. I believe that we have put the cart before the horse and that we need a research effort and I must report to you that I am not a bit satisfied with the research efforts referred to in this bill as being presently administered by the Center for Child Abuse and Neglect at OCD. We do not need to put all the money into demonstration projects, not that they are not valuable. But what we need is the basic kind of research to get at the questions about child abuse. We still don't have the foggiest notion or a consensus definition of what child abuse is. You are passing legislation about a phenomenon whose magnitude we don't know and whose definition experts have yet to agree upon.

Much basic work has to be done and I welcome the suggestion—it is an excellent one—that to understand child abuse better we are going to have to get away from child abuse and look at parenting. That is what Dr. Kempe is talking about. We have to understand better the attachment between a parent and child.

You can read all the child literature you want and never see the word "aggression," although there is a great amount of money spent on aggression research. What I would recommend is some money be put aside for very basic research. There isn't enough money in this bill to do the job I have in mind.

As a result, at the first conference on child abuse I recommended to my old colleagues at the Office of Child Development that OCD take the lead and bring together in IMH, OE, NICHD all of the child abuse research funds. We have hundreds of millions of dollars of research money in this town and there ought to be some way to put some of this bill's money into OCD and say we want a solid research enterprise. We would give OCD $400 million, and ask them to coordinate the other agencies and let them put up something in the order of $15 million. Then we would have the kind of project Professor Gelles talks about, and we could really have a coordinated effort on this.

There is a model in place. OCD did this for early child education. They could do the same thing for child abuse if they would simply get cracking on it.

Senator **Riegle.** Let me just ask at this point, what other specific questions do you think this research ought to be aimed at answering?

Dr. **Zigler.** The very basic questions like what are the characteristics of the abuser. The incidence issue isn't an important one, not because we are not looking for numbers, but because we want to find out where the incidence is higher than other places. That would tell us how to allocate resources. The very basic questions have yet to be answered: Why is a premature child abused more than a nonpremature child, why is the very young child more likely to be abused than the child from 3 to 5, and who is most likely to abuse the child, the mother or father?

I hadn't heard Professor Gelles' data. We are getting a preview, even on the issue of whether more mothers than fathers abuse the child, which Professor Gelles said this morning, gentlemen. We have to have information as to the amount of time that each parent spends with the child. It may be true mothers abuse their child more for the very simple reason they are with their children more. So I think that is the kind of research we need.

Handicapped children; any child who shows any deviance in its normal rate of development is more vulnerable to child abuse. I couldn't begin in the time allotted me to list the thousands of questions that I could ask that we have to have answers to. We need this money to provide badly needed services, but you have to have courage, be courageous and say, look, we could never help any child any more than the knowledge we have about him and the problem we are trying to solve, and I am saying to you on the basis of a very careful look that our knowledge base is inadequate and we are going to have to try to pursue some services while we are pursuing research at the same time.

Senator RIEGLE. You might be interested to know that there are some indications that when this bill passed, other Federal agencies that were already conducting research in this area cut back on that research and on their efforts because they saw this as a responsibility of the new Center. So the whole suggestion of how these various research efforts, both ongoing and potential, get tied together between agencies is obviously a key factor we have to deal with.

Did you have more that you wanted to say with respect to your statement?

Dr. ZIGLER. Just very quickly, because research is not enough. I do believe there are certain things that we can do now that would cut down on incidents and I can give them to you very quickly. First, there should be increased efforts in the family planning area. What Dr. Kempe is reporting is something that we have all encountered: Parents who don't want the child born to them are much more likely to abuse that child. It is that simple.

We should have much more widespread implementation of education for parenthood programs. I am appalled by expectations that parents have. Some children have been killed because they are still defecating in their diaper at the age of 6 months. If we could give parents a better sense of what child development is, a solid education in parenting, that would be an inexpensive way to begin to make an impact on the problem.

I think we should do all we can to reduce the number of premature births. I believe homemaker services are a particularly valuable form of services for families where there is a child abuse problem, and we should do all we can to increase homemaker services, and, finally, since I am convinced that most child abusers are not pathological cases—they are people under great social pressure and social stress—anything that we can do to reduce that stress will reduce the incidence.

The greatest need I can see on this whole social scene is the provision of day care for parents, especially now that we have this pattern of single parents, and of both parents working. If there isn't some respite for these people in the way of day care for their children, all the research in the world isn't going to help the situation very much. So my final appeal would be let us have more good quality day care in this country for the children of working mothers.

Senator RIEGLE. I might make one other comment before we go to the next witness here, with respect to your first point about the inadequacy of the money. That seems to be the inevitable problem with a number of social action problems—they always seem to stand at the end of the line when it comes to Federal funding. I might just say to you and the other panel members and to the people that are in the audience today that decisions that this country is about to make on things like B-1 bombers, which are multimillion dollar decisions, relate directly, in my judgment, to what we can and will do or end up not doing with respect to initiatives of the kind that we are discussing here today. I think that there is a growing awareness of the interrelationship in national spending priorities, people with a very keen sense for unmet needs in the area of child abuse, for example, or other similar kinds of activities, are beginning to see and think about the whole question of how much money is there and where is it going. Decisions on the scale of the B-1 bomber are directly relevant to any discussion about whether we really intend to step up to problems like child abuse or not; we can argue all day long about the right methodology—there will be different points of view and there are ways to work ourselves through those differences of opinion—but the one thing we can't solve any other way is an under-commitment in terms of resources. That has been our historic problem, and I foresee that as a continuing problem until enough of us in the country really face the issue and are prepared to fight the issue of where the resources that we have are going. We have spent plenty of money to figure out how to kill people and precious little as to how we can keep from killing people. We have spent much too little for these youngsters that in some cases are abused to the point where they die. So I would hope that in the background of any of these discussions, this great struggle over resource allocation that is the backdrop against which all of these discussions take place is not forgotten, and that people become more militant with respect to waging that part of the fight, as well.

I think you have concluded your statement and thank you very much.

Our next witness is Mr. Newberger.

Would you like to present your statement?

STATEMENT OF ELI H. NEWBERGER, M.D., DIRECTOR, FAMILY DEVELOPMENT STUDY, CHILDREN'S HOSPITAL MEDICAL CENTER, AND ASSISTANT PROFESSOR OF PEDIATRICS, HARVARD MEDICAL SCHOOL, BOSTON, MASS.

Dr. Newberger. My name is Eli Newberger. I am a pediatrician at Children's Hospital in Boston, Mass., where I direct the family development study.

My comments this morning on child abuse and neglect are organized in three parts. First: Remarks on specific sections of the Child Abuse Prevention and Treatment Act of 1974. Second: Suggestions for a more nearly adequate administrative approach to the mandate of the statute by the Department of Health, Education and Welfare. Third: Observations and recommendations from the perspective of a pediatrician on the evolution of our national concern with child abuse and neglect.

I should like to emphasize at the outset my strong feeling that, important as these problems are, our coming to terms with their many origins and expressions should dovetail with our development of a rational policy on child health and child development. Therefore I have appended to my statement a recent paper, drafted at the request of the Advisory Committee on Child Development of the National Research Council, which addresses these issues and treats child abuse and neglect in a larger social policy context. The changing nature of child health morbidity and mortality obliges us seriously to contemplate the linkage of child health to child welfare and child development services and to consider child and family policy in relation to other national policies on health, employment, housing, education, and income.

I am going to skip over my remarks on the statute as it is written, remarks which are substantially in agreement with those suggested by Dr. Kempe, and move to the second and third portions of my testimony.

Senator **Riegle**. Fine. I might say we are going to make the full text of your statement part of the record, as we will with the other witnesses, along with any addendums that you have, so why don't you proceed with your next point?

Dr. **Newberger**. Thank you, and I will try to be brief.

The problems which have characterized the National Center's approach to the mandate of Public Law 93-247 will not be solved by reorganization alone, but some shifting of lines of responsibility will help. First: An extra-governmental advisory council would support the staff of the Center in essential policymaking functions. Such a council might have avoided the model reporting statute fiasco, which continues to be present. One could attribute to the philosophy of the present National Center reporting law draft the "vacuum cleaner" phenomenon to which Dr. Zigler alluded. States are compelled to expand the definition of child abuse to qualify for Federal moneys under this act, but not to demonstrate improved services. An enormous number of names are being swept into State registers and no services worthy of the name are being provided in several States, other than the fact that the names themselves are being collected and stored. This is a disservice to children and to their families.

The council might have steered the staff toward a more appropriate incidence survey and helped form a rational training strategy. The strange and incoherent research, demonstration, and evaluation effort derived from the coincidence of misadventures, including an ill-advised priority scheme and an impossibly overworked review panel, not all of which might have been avoided had there been advisory councils to account to.

Rather than to pretend that child abuse and neglect are problems which exist in isolation from other issues of child development and health and mental health, the National Center should be brought in close organizational proximity to the other related DHEW programs. This can best be accomplished by a beginning redevelopment of the children's bureau and the establishment of a mechanism at the level of the Secretary's office for integrating children's and family services. National Center programs can and should be integrated with, for example, maternal and child health services, title XX, and adult and child mental health services, most if not all of which are content to have child abuse and neglect be someone else's messy problem. The situation is reminiscent of what one finds in discipline-stratified practice in most community settings; the human dynamics are likely the same at the Federal organizational level.

Although it goes without saying that strong, sound leadership in OCD and OHD is needed, it is well to emphasize the need for a structure which fosters interactive problem-solving among the various technical groupings in the Federal structure. Just as in the best child abuse and neglect clinical practice, the potentialities and limitations of each discipline are acknowledged and appreciated, so too, will an administrative framework which encourages respect, communication, and collaboration among the discipline counterparts produce a richer national program. Now that attention has been focused on child abuse and neglect through the establishment of a national center, the greater attention to the prevention and treatment of the problem will result from a more broadly established Federal effort.

Now I have some remarks with respect to the development of our national concern for child abuse and neglect, and the problems and implications of this concern.

Only recently have child abuse and neglect been identified as problems worthy of the States' attention. Beginning with the publication of Dr. Kempe's important paper—"The Battered Child Syndrome"—in the Journal of the American Medical Association in 1962—there began an effort to try systematically to identify the victims of child abuse and neglect.

This led to the initial development of child abuse and neglect reporting, but it soon became clear that the children who were being reported were from poor and socially marginal families with preferential selection of nonwhite children who received their care in public clinical settings. We still have this illusion that child abuse and neglect are problems of poor people exclusively, even though we now have indirect evidence, such as Dr. Gelles gave us this morning, that the cases are more widespread.

These are problems that affect children of all social classes. But it is the children of poor and socially marginal families who get identified as victims of abuse and neglect.

More affluent families' children, who receive their medical care in private practice settings, where the relationship of clinician to family, the payment structure and the ethics of treating personal information are quite different, may have their injuries characterized as "accidents." The name "accident" connotes an isolated, random event.

In fact, my own research shows that there are important associations between childhood accidents and child abuse and neglect, having to do with a particular child's innate qualities, developmental level and behavior, the child's family's ability to protect him from harm, and the realities of the child's nurturing environment. Accidents at home and in automobiles are the leading cause of child death and suffering and domestic trauma accounts for the greater proportion in preschool children. My point is that many child abuse and neglect cases in richer homes are misdiagnosed as "accidents." These children do not appear on case report rosters. They are often unprotected. And the very diagnostic names "abuse" and "neglect" carry important, implicit judgements, which clinicians are understandably reluctant to make.

It is easier to make the diagnosis of child abuse if you are a physician in an inner-city hospital emergency room or in a clinic for the indigent. Calling a poor, or black or Indian or Chicano mother a bad parent—that is what the diagnosis means—is acceptable there. It is also less painful to report the case, where the family isn't paying you directly, and where you may never see them again.

Our concern with child abuse and neglect, and most research on the problems derives from cases which have come to light through the existing social agencies. We really have focused our attention only on those children who are accessible to study. We still have a very narrow frame and entirely too limited a population to which we direct our efforts. One of the most important things we need to do is to look at the universe of need.

I mean this both in the sense of all the children, rich and poor, white and nonwhite, and in the sense of all manifestations of child abuse and neglect. Our research and demonstration efforts largely ignore the sexual misuse of children, the abuse of children in and by institutions, and the relationships among violence toward adults and violence against children. To address these problems would, to be sure, oblige looking at some troubling social realities and raise the question, in my mind, about whether we really want to deal with the issues of research and practice beyond the level of the individual case.

Are we willing seriously to look at the values and traditions which shape sexual expression and exploitation? Can we face the widespread cruelty to children in institutions for the retarded, the delinquent, and even public schools? Do we really want to know what public assistance stipends pegged below the subsistence level or unemployment does to relations between parents and children? How do battered women, the promotion of violence on TV, and the coercive, degrading nature of many jobs bear on child abuse?

My point is that we are apparently unable to look at the origins and expressions of child abuse at the social level. As David Gil and Richard Gelles have pointed out, we create by our preoccupation with sensational violence in individual homes a kind of smokescreen. There is a macro smokescreen, which lets us as a society ignore uncomfortable problems, like poverty, as well as to ignore other issues of child health and adult and child mental health. As child abuse and neglect were highlighted by the Congress and by the previous administration, resources for children's immunizations and mental health were actually being cut back. And there is a micro smokescreen, where individual families can take comfort in knowing that those are the bad parents who abuse their kind over there. What we do in our home is OK. This helps us not to think about, for example, our misuse of corporal punishment and the emotional poverty of so many of our lives.

I need not add, perhaps, that the administrators of the Federal research and demonstration effort are also politically sensitive. Any federally based program is going to reflect the administration's and the Congress's values. Reading the Congressional Record in 1973, before this bill first passed, gives one a pretty good idea about what we want to do and find out about child abuse and neglect, and what we don't.

I think some of the criticisms of the way the bill has been implemented are well taken. But I disagree profoundly with the notion that we ought not to have an important portion of that money available for research and development studies.

There is no way a $20 million program can begin to answer the service needs of the million or so children whom we, through surveys, believe are abused and neglected each year.

I really don't believe that we have either an adequate rational base for the treatment of child abuse and neglect nor have we adequately disseminated technology, even to the extent that we know what good practice is. This is partly due to resources, but it also partly has to do with the need for theory building in this field.

We have yet to develop a theoretical base that enables us competently to deal with the many kinds of family problems that culminate in the physical symptoms of child abuse and neglect. We clearly need not only better knowledge in terms of understanding the type of distribution of family problems, but we also need to have much more accurate understanding of the relationship of children's symptoms to family dysfunctions. We need to know what enables parents to cope and, importantly, what realities are associated with family competency and strength. This, in turn, will make for a more informed and rational clinical practice. I think it is much more a problem of an adequate conceptual and methodologic base of practice than a problem of not having sufficiently the ability to apply the tools of what we already know.

Personally I cannot presume to say what percentage of available resources ought to be devoted to research and development as opposed to service. I think that there ought to be both in the Federal program. But I think that a hefty portion of the Federal appropriation for child abuse and neglect must be to research and demonstration as opposed to service. I think that it is the research and demonstration efforts that are going to lead to the same kinds of pioneering advances that we have seen in other areas.

In the paper which he gave at the National Conference on Child Abuse in Atlanta a year ago January, Dr. Edward Zigler, former director of the Office of Child Development and Sterling professor of psychology at Yale, noted that we are in child abuse and neglect where mental retardation was in the 1950's. This didn't make many of the assembled experts too happy, as you can imagine. But it made us think for a moment, and to worry about our headlong action in this field. I believe a stronger and broader foundation for actions is urgently needed.

Senator RIEGLE. Thank you for those thoughts and insights.

[The prepared statement of Dr. Newberger and material referred to follows:]

Child Abuse and Neglect: Toward a Stronger and Broader Foundation for Practice and Policy

Testimony before the U.S. Senate Subcommittee on Child and Human Development by Eli H. Newberger, M.D.*

Hearing on Child Abuse and Neglect

April 6, 1977

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My comments this morning on child abuse and neglect are organized in three parts: first, remarks on specific sections of the Child Abuse Prevention and Treatment Act of 1974 (Public Law 93-247); second, suggestions for a more nearly adequate administrative approach to the mandate of the statute by the Department of Health, Education, and Welfare; and third, observations and recommendations from the perspective of a pediatrician on the evolution of our national concern with child abuse and neglect. I should like to emphasize at the outset my strong feeling that, important as these problems are, our coming to terms with their many origins and expressions should dovetail with our development of a rational policy on child health and child development. Therefore I have appended to my statement a recent paper, drafted at the request of the Advisory Committee on Child Development of the National Research Council, which addresses these issues and treats child abuse and neglect in a larger social policy context. The changing nature of child health morbidity and mortality obliges us seriously to contemplate the linkage of child health to child welfare and child development services and to consider child and family policy in relation to other national policies on health, employment, housing, education, and income. (Appendix: Child Health in America: Toward a Rational Public Policy, by Eli H. Newberger, Carolyn Moore Newberger, and Julius B. Richmond, published in the Milbank Memorial Fund Quarterly Health and Society 54:3, 249-298, 1976).

I. Remarks on the Child Abuse Prevention and Treatment Act

Section 2(b) (6) specifically mandates the Secretary to conduct a full study of "the national incidence of child abuse and neglect". This mandate is probably unnecessary; further, interpreted literally, it has resulted in an unproductive expenditure of resources. Rather, the adequacy of local services needs urgently to be assessed, both by measurement of cases on the books (this is prevalence, not incidence) and by evaluation of the delivery capacity of the several elements of service structure.

Section 4 can be strengthened as follows:

4 (a) (1): for the development and establishment of training programs which foster cooperation of professionals and institutuions of the several disciplines to identify, prevent, and treat child abuse and neglect. (Rationale: the discipline-stratified approach to training favored by the National Center on Child Abuse and Neglect in DHEW has effectively perpetuated traditional turf boundaries and inhibited the development of interdisciplinary work across institutional lines).

4 (a) (2): add "at least one center to be known as a regional resource center shall be established and maintained in each of the ten DHEW regions. The Secretary shall establish standards of staff experience in direct services and research in child abuse and neglect, availability of direct service models for the evaluation and treatment of child abuse and neglect, preparation for expert consultation in the areas of child abuse and neglect, and other important resources for projects funded under this section". (Rationale: this wording, suggested by Dr. C. Henry Kempe, would enable the development and perpetuation of centers of professional excellence in the field, which would buttress the evolution of sound clinical practice, research, and policy. These three areas are related, and some greater assurance of permanency is needed to attract and keep top-notch people in this field. The state of the art -- and the rational basis for policy -- need continuing support, in no small part due to the formid-

able complexity of the clinical, research, and policy issues and to the limited number of professional groups who can move the field ahead).

4 (b) (2) (D): In order for states to qualify for assistance, there should be assurance of adequate protective service programs at the county level, in accord with Federal standards. Each county should demonstrate linkages to services other than child welfare services, and a representative citizen group should participate in defining and overseeing the program. (Rationale: this is to foster service integration and responsiveness to local needs, in addition to laying the groundwork for citizen-based Child Development or Child Health councils in a future child development policy).

Additionally, the legislation should mandate an extra-governmental advisory council to the National Center on Child Abuse and Neglect which would guide and support the development of program and policy, especially in the research and evaluation area.

II. Suggestions For a More Nearly Adequate Administration of the Child Abuse Prevention and Treatment Act

The problems which have characterized the National Center's approach to the mandate of P.L. 93-247 will not be solved by reorganization alone, but some shifting of lines of responsibility will help. First, an extra-governmental advisory council would support the staff of the Center in essential policy-making functions. (Such a council might have avoided the model reporting statute fiasco, which continues to the present. It might have steered the staff toward a more appropriate incidence survey and helped form a rational training strategy. The strange and incoherent research, demonstration, and evaluation effort derived from a coincidence of misadventures, including an ill-advised priority scheme and an impossibly overworked review panel, not all of which might have been avoided had there byen advisory council to account to).

Rather than to pretend that child abuse and neglect and problems which exist in isolation from other issues of child development and health and mental health, the National Center should be brought in close organizational proximity to the other related DHEW programs. This can best be accomplished by a beginning redevelopment of the Children's Bureau and the establishment of a mechanism at the level of the Secretary's office for integrating children's and family services. National Center programs can and should be integrated with, for example, maternal and child health services, Title XX, and adult and child mental health services, most if not all of which are content to have child abuse and neglect be someone else's messy problem. (The situation is reminiscent of what one finds in discipline-stratified practice in most community settings; the human dynamics are likely the same).

Although it goes without saying that strong, sound leadership in OCD and OHD is needed, it is well to emphasize the need for a structure which fosters interactive problem-solving among the various technical groupings in the Federal structure. Just as in the best child abuse and neglect clinical practice the potentialities and limitations of each discipline are acknowledged and appreciated, so too will an administrative framework which encourages respect, communication, and collaboration among the discipline counterparts produce a richer national program. Now that attention has been focused on child abuse and neglect through the establishment of a National Center, the greater attention to the prevention and treatment of the prevention and treatment of the problem will result from a more broadly established Federal effort.

III. The Development of our National Concern for Child Abuse and Neglect: Problems and Implications.

Only recently have child abuse and neglect been identified as problems worthy of the states' attention. Beginning with the publication of Henry Kempe's important paper - "The Battered Child Syndrome" in the Journal of the American Medical Association in 1962 - there began an effort to try systematically to identify the victims of child abuse and neglect.

This led to the initial development of child abuse and neglect reporting. But it soon became clear that the children who were being reported were from poor and socially marginal families with preferential selection of nonwhite children who received their care in public clinical settings. We still have this illusion that child abuse and neglect are problems of poor people exclusively - even though we now have indirect evidence that the cases are more widespread.

These are problems that affect children of all social classes. But it is the children of poor and socially marginal families who get identified as victims of abuse and neglect.

More affluent families' children, who receive their medical care in private practice settings, where the relationship of clinician to family, the payment structure, and the ethics of treating personal information are quite different, may have their injuries characterized as "accidents". The name "accident" connotes an isolated, random event.

In fact, my own research shows that there are important associations between childhood accidents and child abuse and neglect, having to do with a particular child's innate qualities, developmental level and behavior, the child's family's ability to protect him from harm, and the realities of the child's nurturing environment. Accidents at home and in automobiles are the leading cause of child death and suffering and domestic trauma accounts for the greater proportion in preschool children. My point is that many child abuse and neglect cases in richer homes are mis-diagnosed as "accidents". These children do not appear on case report rosters. They are often unprotected. And the very diagnostic names "abuse" and "neglect" carry important, implicit judgements, which clinicians are understandably reluctant to make.

It's easier to make the diagnosis of child abuse if you are a physician in an inner-city hospital emergency room or in a clinic for the indigent. Calling a poor, or Black, or Indian, or Chicano mother a bad parent -- that's what the diagnosis means -- is acceptable there. It's also less painful to report the case, where the family isn't paying you directly, and where you may never see them again.

Our concern with child abuse and neglect, and most research on the problems derives from cases which have come to light through the existing social agencies. We really have focused our attention only on those children who are accessible to study. We still have a very narrow frame and entirely too limited a population to which we direct our efforts. One of the most important things we need to do is to look at the universe of need.

I mean this both in the sense of all the children, rich and poor, white and nonwhite, and in the sense of all manifestations of child abuse and neglect. Our R and D (research and demonstration) efforts largely ignore the sexual misuse of children, the abuse of children in and by institutions, and the relationships among violence toward adults and violence against children. To address these problems would, to be sure, oblige looking at some troubling social realities and raise the question-in my mind-about whether we really want to deal with the issues of research and practice beyond the level of individual case.

Are we willing seriously to look at the values and traditions which shape sexual expression and exploitation? Can we face the widespread cruelty to children in institutions for the retarded, the delinquent - and even public schools? Do we really want to know what public assistance stipends pegged below the subsistence level or unemployment does to relations between parents and children? How do battered women, th promotion of violence on TV, and the coercive, degrading nature of many jobs bear on child abuse?

My point is that we are apparently unable to look at the origins and expressions of child abuse at the social level. As David Gil and Richard Gelles have pointed out, we create by our preoccupation with sensational violence in individual homes a kind of smokescreen. There's a "macro" smokescreen, which lets us as a society ignore uncomfortable problems - like poverty - as well as to ignore other issues of child health and adult and child mental health. As child abuse and neglect were highlighted by the Congress and by the previous administration, resources for children's immunizations and mental health were actually being cut back. And there's a "micro" smokescreen, where individual families can take comfort in knowing that those are the bad parents who abuse their kind over there. What we do in our home is o.k. This helps us not to think about - for example - our acceptance of corporal punishment and the emotional poverty of so many of our lives.

I need not add, perhaps, that the administrators of the federal R and D effort are also acutely politically sensitive. Any federally based program is going to reflect the administration's and the congress's values. Reading the Congressional Record in 1973, before this bill first passed, gives one a pretty good idea about what we want to do and find out about child abuse and neglect - and what we don't.

I think some of the criticisms of the way the bill has been implemented are well taken. But I disagree profoundly with the notion that we ought not to have an important portion of that money available for research and development studies.

There's no way a $20 million program can begin to answer the service needs of the million or so children whom we, through surveys, believe are abused and neglected each year.

I really don't believe that we have either an adequate rational base for the treatment of child abuse and neglect nor have we adequately disseminated technology, even to the extent that we know what good practice is. Now, this partly has to do with resources, but it also partly has to do with the need for "theory building" in this field.

We have yet to develop a theoretical base that enables us competently to deal with the many kinds of family problems that culminate in the physical symptoms of child abuse and neglect. We clearly need not only better knowledge in terms of understanding the type and distribution of family problems but we also need to have much more accurate understanding of the relationship of children's symptoms to family dysfunctions. We need to know what enables parents to cope and, importantly, what realities are associated with family competency and strength. This, in turn, will make for a more informed and rational clinical practice. I think it's much more a problem of an adequate conceptual and methodologic base of practice than a problem of not having sufficiently the ability to apply the tools of what we already know.

I cannot presume to say what percentage of available resources ought to be devoted to research and development as opposed to service. I think that there ought to be both in the federal program. But I think that a hefty portion of the federal appropriation for child abuse and neglect must go to R and D. I think that it's the research and demonstration efforts that are going to lead to the same kinds of pioneering advances that we've seen in other areas.

In a lecture at the national conference on child abuse in Atlanta a year ago January, Dr. Edward Zigler, former director of the Office of Child Development and Sterling professor of psychology at Yale, noted that we are in child abuse and neglect where mental retardation was in the 1950s. This didn't make many of the assembled experts too happy, as you can imagine. But it made us think for a moment, and to worry about our headlong action in this field. A stronger and broader foundation for action is urgently needed.

Child Health in America: Toward a Rational Public Policy

ELI H. NEWBERGER
CAROLYN MOORE NEWBERGER
JULIUS B. RICHMOND

Analysis of currently available data on mortality and morbidity indicates that the major organic illnesses of childhood, and their developmental consequences, are susceptible in part to the technical interventions of American medical science. Environmental forces, however, exert a powerful impact on the health of children in the United States, manifested both in the disproportionate toll of most organic diseases on poor and nonwhite populations and in such increasingly important symptoms of familial, social, and behavioral distress as child abuse, accidents, and childhood suicide. Review of the nature, quality, and distribution of child health services demonstrates a systemic inability to reach and treat the children most in need of them. A rational basis for child health policy includes: appropriate concepts of health, disease, and preventive and therapeutic intervention; a capacity to acknowledge, to measure, and to act on the familial and environmental, as well as the medical, sources of illness; an orientation to the developmental and social implications of good and poor child health; and a commitment to enable all children to receive health services.

The data and this policy framework lead to these program recommendations: the channeling of resources into a more rational system which guarantees equity and access; a planning and program implementation mechanism which addresses the health needs of diverse local populations and which makes real the advocacy concept; a screening, evaluation, and surveillance methodology; a delivery system which both applies preventive and curative health technology and addresses basic life needs of children; and a coherent program for the training, assignment, and supervision of the several kinds of manpower which such a system would require.

Introduction: Assumptions and Objectives

As we enter the United States' third century and contemplate the state of the health of its children, we might identify four cardinal assumptions underlying the present health care system.

The first assumption is that *the development of technology is tantamount to the control of illness.* This century has seen extraordinary progress in our ability to control major organic illness phenomena, yet the fruits of this progress do not reach all of our children. There are large groups of children who either are unserved or poorly served by health services in America.

A second assumption is that *health care for children is equivalent to providing them with immunizations and with acute ill-*

ness intervention. How to promote children's health is not, in fact, a primary consideration in the overall scheme of health services in the United States, particularly for children in low-income families. The relationship between a child's social and physical context, including his family's health and economic status, and his later functioning as an adult is generally ignored in present practice.

A third assumption is that *health services are properly and best dispensed by a physician.* An appropriate concept of child health obliges re-examination of this assumption. The issue is not only concerned with the conservation of precious and highly trained manpower, and who is competent to perform which technical tasks, but also with defining what are the commitments and responsibilities to children's health and who assumes them.

The fourth assumption is that more of the same will do a better job, or that *the provision of adequate services insures their use.* If we do not yet understand what is necessary to promote good health, awareness of the various needs of diverse populations which are not and cannot be met by our current health structures necessitates a re-examination of health delivery mechanisms as well as the content of health services.

The task of this paper is to address and challenge these assumptions by examining (1) *the status of child health:* the major health problems of children in the United States, their distribution, and how and in what ways our current health system responds and fails to respond to these problems; (2) *the context of child health:* the conditions, services, and circumstances which most importantly affect children's present and future health and life functioning; the importance to life functioning of the environment in which a child grows as well as the "services" which he and his family receive; (3) *the concept of child health:* the conceptual basis for current practice, and alternative concepts for the re-examination and restructuring of health care for children; and (4) *program recommendations* for a better health structure.

The Status of Child Health in The United States

Principal Causes of Death and Illness among American Children

Mortality In the decade 1964–1974 the infant mortality rate (deaths in the first year of life per 1,000 children born alive) declined from 24.8 to 16.5. The major portion of this toll still occurs during the first month of life.

There remain, however, great disparities among the rates for children of differing racial backgrounds and geographic settings (Wegman, 1975). In the District of Columbia, 1974 witnessed an increase in the infant mortality rate to 26.0 from 24.2 in 1973; this was the highest rate recorded in a state-by-state breakdown of the data. The uniquely unfavorable experience of the nation's capital, with its large impoverished black community, reflects the vulnerability of nonwhite, poor babies elsewhere in the United States (Institute of Medicine, 1973). Infant mortality rates for nonwhites are over 150 percent those of whites (National Center for Health Statistics, 1974a; National Council of Organizations for Children and Youth, 1976).

Causes of infant mortality and corresponding infant mortality rates for 1974 are congenital anomalies (2.9), influenza and pneumonia (0.9), birth injuries (0.6), asphyxia of the newborn, unspecified (1.5), immaturity, unqualified (1.5), other diseases of early infancy (5.3), certain gastrointestinal diseases (0.3) and all other causes (3.7). If one considers that in 1973, the United States placed sixteenth in the world in infant mortality, behind East Germany and Hong Kong (Wegman, 1975), and recognizes the impact on infant mortality of the investments in maternal and child health services in the United Kingdom and Sweden (Wallace, 1975), it is clear that much of this toll might have been prevented. This is also the clear implication of Kessner's important study of the relationship between services and infant death in New York City (Institute of Medicine, 1973).

In the population of children age one to four years, the principal causes of death and their frequency per 100,000 estimated population in 1973 (death rate) are accidents (19.6), motor vehicle accidents (12.3), congenital anomalies (9.6), malignant neoplasms (6.4), influenza and pneumonia (5.9), homicide (2.5), diseases of the heart (2.1), meningitis (1.6), enteritis and other diarrheal diseases (1.0), cerebrovascular diseases (1.0), and anemias (0.6) (National Center for Health Statistics, 1976a: 359). For children five to fourteen years of age, the principal causes of death and the death rates in 1973 are motor vehicle accidents (10.6), all other accidents (10.2), malignant neoplasms (5.4), congenital anomalies (2.2), influenza and pneumonia (1.4), homicide (1.1), diseases of the heart (1.0), cerebrovascular diseases (0.6), suicide (0.4), benign neoplasms and neoplasms of unspecified nature (0.4), and anemias (0.3) (National Center for Health Statistics, 1976a: 361).

Although mortality rates in early childhood demonstrate a greater decline since 1900 than the rates for any other group, the death rate for minority preschool children remains about 50 percent higher than the rate for their white counterparts (National Center for Health Statistics, 1976a: 340–341). Wegman (1975) points out that it is well to recognize that by far the greater part of the decline in childhood mortality occurred before 1940, prior to the major introduction of antibiotics and chemotherapy. This may be ascribed to environmental improvement and to better living standards.

The extraordinary mortality due to accidents is distributed unequally in regard to ethnic and socioeconomic status. An analysis of accident death rates performed by the National Institute of Child Health and Human Development (1971) indicates a 250 percent greater infant mortality rate resulting from accidents for nonwhite children, and death rates for older children exceeding 150 percent of the rates for whites. Inordinately high death rates from infectious diseases, influenza, and pneumonia, for minority and poor children (National Center for Health Statistics, 1976a; Richmond and Weinberger, 1970) likewise suggest a disproportionate impact of environmental forces on this population.

Morbidity Although data on acute and chronic illness of children in the United States are available from a number of surveys, we lack such a data base on childhood morbidity as is systematically developed for mortality. This is partly but not exclusively due to the nature of illness in children and to the varying utilization of health services: most symptoms of pediatric illness are limited in duration if not in intensity, and not all come to the attention of health providers.

Useful recent data comes from the household interviews performed in 1973 and 1974 as part of the National Health Survey (National Center for Health Statistics, 1975). The most frequent acute conditions reported by parents of children under six years of age (excluding all conditions involving neither restricted activity nor medical attention) with extrapolated incidence estimates in thousands, are: respiratory conditions (32,486), infective and parasitic diseases (9,864), other acute conditions (9,515), injuries (7,211), and digestive system conditions (2,099). For children six to 16 years of age, the illnesses and incidence estimates are: respiratory conditions (55,558), injuries (16,422), infective and parasitic conditions (13,384), other acute conditions (10,614), and digestive system conditions (4,593).

Acute illness prompts most childhood medical visits, but poor children are less likely to see a doctor than more affluent children, even though they suffer transient disability more frequently and are more susceptive to handicaps which exert a lasting effect on their productivity (Lowe and Alexander, 1974: 149). Brain damage and mental retardation correlate closely with low birth weight and prematurity (Niswander and Gordon, 1972), which in turn are associated frequently with low social class, minority group status, and lack of access to adequate prenatal care (Institute of Medicine, 1973).

Malnutrition has been found to be a problem of major importance among our country's poor (Carter, 1974; Owen et al., 1974). Over 10 percent of poor children and over 30 percent of poor infants in some surveys are found to suffer from iron deficiency anemia (Katzman et al., 1972; Filer, 1969; Owen et al., 1971). When we realize that roughly one quarter of our nation's children live in families whose income falls below the minimum level considered necessary for adequate nutrition, the magnitude of the problem of undernutrition becomes apparent (National Council on Hunger and Malnutrition . . ., 1972). Despite the law that federal food programs are to be available to all poor families, in 1972 only one-third of poverty-stricken children attending public school were in school lunch programs, and in 1974 only 35.6 percent of poor families participated in food-stamp programs. Indeed, our poorest families cannot afford to purchase food stamps (Pollack, 1975). Childhood malnutrition can be understood—and intervention directed—both in terms of available nutrients and in reference to the child's familial, social, and economic setting which may restrict the availability and utilization of food (Newberger et al., 1976).

The effects of malnutrition on the growing child may be grave.

Both human and animal studies show that a combination of prenatal and postnatal undernutrition may jeopardize brain development. It has been estimated that nearly 60 percent of all pregnant women with incomes below the poverty level and 44 percent of pregnant women at two to three times the poverty level consume fewer calories than are necessary for the normal intrauterine development of their children (Bergner and Susser, 1970; Livingston et al., 1975). Malnutrition during the first months of extrauterine life may result in a decrease of up to 20 percent of the normal number of animal brain cells (Winick, 1971). Prolonged malnutrition, particularly if it occurs before five years of age, may lastingly affect learning ability, body growth, and rate of maturation, as well as ultimate size and productivity (Monckeberg et al., 1972; Food and Nutrition Board, National Academy of Sciences, 1974).

Dental caries rank high among the health problems of children (National Center for Health Statistics, 1974b; Creighton, 1969; Whitenhurst et al., 1968). Yet in 1971, there was a lower dentist-to-population ratio than in 1951 (National Center for Health Statistics, 1973). Examination of children enrolling in Headstart programs during the summer of 1966 revealed that between 40 and 70 percent had dental caries (North, 1967). And, when poor children receive dental treatment, their carious teeth seem more likely to be extracted than filled (National Center for Health Statistics, 1974b).

Twenty-one million of the 83.8 million youth aged 0 to 21 in the United States required eye care, of whom 180,000 were partially sighted, and of whom 13,000 were totally blind (Rand Corporation, 1974b). In this same year, approximately 8 million had mild hearing impairment, 440,000 were hard of hearing, and about 50,000 were profoundly deaf (Rand Corporation, 1974b). Many of the conditions which predispose to sensory handicap, such as prematurity, infectious disease, and accidents, are found disproportionately among the poor and nonwhite populations. Further, the immunizations against measles, mumps, rubella, and Rh sensitivity, which are among the primary tools for handicap prevention, are neither equally nor adequately distributed (Center for Disease Control, 1975).

The major organic illnesses of childhood are increasingly being overcome by medical science. Great progress has been made toward the control of infectious diseases, surgical diseases, immune disorders, and cancer. Amniocentesis has made the antenatal diagnosis of genetic disorders possible, and counseling, birth control, and the increasing acceptance of abortion have made possible the prospect of their elimination (Nadler, 1976). The availability of abortion also appears to be associated with a decrease in the frequency of prematurity (Pakter and Nelson, 1974) and in maternal and infant mortality (Pakter et al., 1973).

Behavioral and Psychophysiologic Illness Behavior and psychophysiologic illnesses, on the other hand, appear to be increasingly prevalent. Haggerty, Roghmann, and Pless (1975) have drawn attention to the significance of this "new morbidity" for child health practice. But the "mental health" of children is largely neglected (Joint Commission on the Mental Health of Children, 1970), notwithstanding the increasing frequency of such markers of child mental illness as suicide and rates of psychiatric hospitalization (National Center for Health Statistics, 1976a; National Institute of Mental Health, 1974a; 1974b). "Special education" classes, where they exist, are often dumping grounds for "problem" children (Task Force on Children Out of School, 1970).

Schools for the emotionally disturbed and the retarded are too often prisons for children with no alternative; they are documented in the lay press in the disclosures of conditions at the Willowbrook School in New York State and the Belchertown State School in Massachusetts. Gil's review (1974:83) of data on American children in institutions and the goals and methods of institutional programs concludes: "residential child care can operate to achieve constructive and liberative objectives as well as destructive and oppressive ones. The use to which private boarding schools are put demonstrates this. Our child welfare institutions could be transformed into channels for equality, freedom and creativity if, and when, we redefine their social purpose in these terms. To achieve this requires a broad commitment to the intrinsic and equal worth of every child."

The uncritical use of amphetamines among "hyperactive" elementary school children illustrates the willingness with which some professionals may adopt means of suppressing rather than treating the familial, environmental, and endogenous causes of deviant child behavior. "Now that there appear to be at least 300,000 children in elementary schools in the United States on psychotropic medication for school difficulties, and that in one county, the school nurses administer medication to 61 percent of these children, it behooves both physicians and schools to establish a close liaison in their management efforts" (Krager and Safer, 1974:1120).

Accidents, by far the greatest cause of mortality and morbidity among children, can be considered as part of a complex of illnesses which are socially and environmentally, as opposed to primarily organically, derived. Accidents, child abuse and neglect, plumbism, ingestions of poisonous substances, and failure to thrive, all reflect situations in which a young child cannot sufficiently be protected in a hazardous environment, either from the exigencies of the physical setting inself, or from his parents' problems in nurturing him.

Plumbism, or lead poisoning, is found almost exclusively in the urban slums (Blanksma et al., 1969). Lead poisoning is generally an insidious disease. A child can carry dangerously high levels of lead without showing external symptoms. Lead poisoning by a recent estimate affects 400,000 American children annually; it causes 200 deaths. The report observed that 16,000 of the 400,000 children affected required treatment, 3,200 incurred moderate to severe brain damage, and 800 children incurred brain damage severe enough to require care for the rest of their lives Lead poisoning is a preventable disease, yet it may cripple more children than did polio before the antipoliomyelitis vaccines were developed (Needleman, 1975).

Treatment involves screening, deleading afflicted children with chelating agents, and renovating some *seven million units of housing* painted with lead-based paint. Atmospheric lead in the vicinity of a secondary lead smelter in Memphis, Tennessee, was associated both with symptoms of lead toxicity and high blood lead levels in smelter workers and their children (Center for Disease Control, 1976a: 85–86):

> Such reports emphasize the importance of improved work practices and engineering controls not only in safeguarding worker health, but also in shielding families of workers from contact with toxic industrial materials.

Although the government is increasingly aware of the problem, money to treat and eliminate lead poisoning has been committed in pitifully small amounts. The few city programs which exist have clearly inadequate resources to control the disease because of limited local funds. Acknowledgment of the problem and the signing of the Lead-Based Paint Poisoning Prevention Act is unfortunately meaningless if the budget does not include adequate funds for implementing effective programs.

Accurate incidence statistics for child abuse are not yet available, and can only be estimated. Although the actual numbers of reported cases indicate a nationwide annual incidence of up to 200,000 cases a year, indirectly acquired data from a survey in which a nationwide sample of respondents in a population representative of a standard metropolitan statistical area were asked whether they knew personally of serious injuries inflicted on children during the previous year indicated between 2.5 and 4.8 million cases (American Humane Association, 1976; Gil, 1970). This extrapolation to the national population has been subject to careful analysis and is felt in general to represent an upper margin of estimate (Light, 1973). When taken together with estimates of the prevalence of cases on the books of child welfare agencies and the woefully inadequate state of American child welfare services, this indicates a problem of enormous magnitude (Newberger and Hyde, 1975; Jenkins, 1974; Newberger and Daniel, 1976).

The impact on child health of the social acceptance of violence and its promotion on television has recently been underlined by Somers (1976). Notwithstanding a substantial literature on the effects of television violence on children's behavior, the industry, government, and health professionals all appear reluctant to acknowledge and to act on this potent source of harm. Violence sells. Somers quotes S. Strickland's 1975 address to the Women's National Democratic Club (Somers, 1976: 812): ". . . between the ages of five and fifteen, the average American child will view the killing of more than 13,000 persons on television."

A rich understanding of child health and its meaning for later functioning are offered in two recent studies. Haggerty et al. (1975:316) note in the conclusion of a broadly conceived investigation into child health in the setting of Monroe County, New York: "the current major health problems of children, as seen by the community, are those that would have barely been mentioned a generation ago. Learning difficulties, visual problems and the problems of adolescents in coping and adjusting are today the most common concerns about children." The final volume of the 1,000-family survey of Newcastle Upon Tyne, England (Miller et al., 1974:298) gives longitudinal followup of a cohort of children born in 1947 and a vivid impression of the significance of health and ill health for human development which helps inform our more limited understanding of the consequences of childhood morbidity in the United States:

> The health of the children in our city was never better than in the years of our study. Yet at fifteen not less than one in five had either handicap, recurrent illness, intellectual limitation, poor education performance or severe difficulties of emotional or social adaptation. This residual disability is the true measure of our failure to deal effectively with the physical and educational discorders of children, and we do not yet know how much of the effects of physical illness or emotional disturbance will only become apparent later in life.

The Gap Between Technology and Delivery

The Distribution of Preventive Health Care Measles, diphtheria, and polio are largely preventable diseases, thanks to the development of effective vaccines. In 1962, Congress passed the Vaccination Assistance Act, whose funds enabled the vaccination of millions of children against a variety of diseases, including the above three. The 1974 United States Immunization Survey (Center for Disease Control, 1975) suggests a prevalence of completed polio immunizations in children aged one to four of 63.1 percent; for diphtheria-tetanus-pertussis immunization of 69.5 percent; and for measles 64.5 percent. In general, poor children and rural children received these preventive services less frequently; in this respect immunizations serve as an accurate marker of the distribution of child health services (National Center for Health Statistics, 1976a). (In fact, immunizations are among the simplest services to deliver, and the prevalence estimates from the Immunization Survey provide if anything an inflated qualitative impression of children's contact with health services.) The unequal distribution of immunizations has a predictable impact.

In Des Moines County, Iowa, from July 1971 to January 1972, a measles epidemic took place. It was found that the effectiveness of the measles vaccine was over 90 percent and that "the overwhelming majority of cases continues to occur in unvaccinated children. The effectiveness of the vaccine was also demonstrated by the sharp decline in the number of cases two weeks after the vaccination campaign" (Center for Disease Control, 1972a:13).

Diphtheria was observed in epidemic form on or near the Navajo Indian Reservation in Arizona and New Mexico. Although there were no deaths, five patients had myocarditis and/or varying degrees of neurologic involvement, and two of these had respiratory arrests and required artificial ventilation; of the 44 cases six had been fully vaccinated (Center for Disease Control, 1973; Munford et al., 1974).

Most of the 31 cases in the pertussis outbreak in Knoxvilie, Tennessee, between May and December 1975, occurred in children from low-income neighborhoods and housing projects. Although three cases (10%) were fully immunized for their ages, 15 (48%) were partially immunized, and 13 (42%) had received no pertussis vaccine at all. Immunization surveys demonstrated much higher immunization levels in more affluent children (Center for Disease Control, 1976b).

The possibility of polio outbreaks is also of concern. In a serologic survey of 289 Syracuse children two to six years old, 55 percent had no demonstrable antibodies to polio virus Type 1, and 62 percent were negative for Type 3 (Lamb and Feldman, 1971). The population at risk is mainly poor and preschool. Most of the small outbreaks of paralytic poliomyelitis during recent years have concentrated in inner-city areas.

The problem with implementing urgently needed vaccination programs is only partly one of money and of delivery, although these are the major necessary—and lacking—elements in this aspect of preventive child health. A coherent strategy for anticipating and preventing these illnesses would address the social as well as economic costs and benefits of action and inaction. A mathematical benefit-cost model with important policy implications has been developed by Schoenbaum et al. (1976) and has been applied to rubella immunizations. (The authors conclude that current United States practice of vaccinating children once at an early age prevents fewer cases of congenital rubella syndrome than were the vaccine to be offered to females at the age of 12; "benefits" and "costs" are also defined both in dollars and cents and in quantifiable human terms, both for the congenital rubella syndrome and for acute rubella infection.)

Delivery of Health Services Even though the prevalence of handicapping conditions and their antecedents in childhood illness is disproportionately greater among the poor, only 15.7 percent of children under 17 from families whose annual income is under $2,000 visit a physician during a one-year period, as compared to 53.9 percent and 57.6 percent, respectively, of children whose family income is $10,000 and above and $15,000 and above (National Center for Health Statistics, 1974a).

Differences in utilization of services cannot be ascribed solely to lack of money to pay for them, or to lack of availability. Bergner and Yerby (1968:543–544) eloquently describe some of the barriers which make the poor less likely to take preventive measures or to seek early health care for acute illnesses:

> The location of services, the availability of transportation and the hours at which the services are offered all affect the true availability of the services. Too often these arrangements reflect that which is convenient for the provider of service and quite inconvenient for the patient . . . in many places it may be several weeks before (the patient) can be fit into the schedule. In many clinics he faces the prospects of long waits in dingy surroundings. He may be addressed in a manner that clearly indicates that the system regards him as just another burden with no personal dignity. He is all too likely to receive a cursory inspection or a single injection and non-communicative word or two and be sent on his way. Examinations may be performed without a modicum of privacy, and his problems discussed within easy hearing of other patients. If a course of treatment is prescribed, too little consideration may be given to whether he can possibly carry it out—physically, emotionally, or financially . . . The patient's needs, expectations and priorities are not allowed to interfere with the functioning of the system.

Such services as these militate against adequate health care for those people who have no better alternatives. The country has two systems of health care: private and frequently inadequate care for those who can pay; and "public" care, or no care, for those who cannot. "Public" care, much of which is provided in hospital outpatient clinics, is generally fragmented, difficult to get to, overcrowded, and resorted to only in times of crisis, when the affliction is too grave not to seek help, however distasteful it may be (National Center for Health Statistics, 1974a).

For people whose family income is over $15,000, combined traveling and waiting time to see a physician is 43 minutes; it is 81 minutes for those on welfare and 66 minutes for other poor (National Council of Organizations for Children and Youth, 1976).

Miller (1976) notes that although children have benefited from the Title XIX (Medicaid) program relatively less than their elders, the utilization of medical services by poor, nonwhite, and rural children has increased by this entitlement. But the financial floor has not provided a sturdy base for a child health program, as pointed out by Foltz and Brown (1975). Within five years of the 1965 enactment of Title XIX, it became the major public child health program, serving nearly 10 percent of all children and commanding over twice the resources of the Title V health programs administered by the U.S. Children's Bureau and state health departments. The 1967 amendment to the Social Security Act linked the two programs (one a welfare-based payment structure, the other a health service) by mandating early and periodic screening, diagnosis, and treatment ("EPSDT") for Medicaid-eligible children and, for those served through Title V, "early identification of children in need of health care and services, and for health care and treatment." In addition to the four-year lapse before regulations for EPSDT were promulgated by the Department of Health, Education, and Welfare, the program fell heir to systemic problems of both the federal and state welfare and health bureaucracies. The lapse demonstrated the Administration's priorities, as pointed out by the Comptroller General of the United States (1975) in quoting HEW Secretary Caspar Weinberger, who said the "embarrassingly long period of delay and debate [was] occasioned mainly by a concern over the impact on Federal and State budgets and on States' medical resources."

In a study of EPSDT and Medicaid in Connecticut, a relatively wealthy state with many medical resources, Foltz and Brown (1975) detail why EPSDT had little impact on child health services: no new services were developed; a fragmented child health system was perpetuated; a state health department was limited to serving as technical adviser and facilitator; and a conflict between federal and state policy on eligibility for service led to a de facto lowering of the priority of poor children's health services. (A state decision to reduce welfare costs limited EPSDT funding, and the federal government did not enforce compliance.)

For families who can pay, the private health system, though expensive, unevenly distributed, and in some ways inefficient, can deliver excellent child health care. The differences between the two systems, and their relative costs, have been reviewed by Lowe and Alexander (1974). They conclude that poor children receive less health service in all ways.

The facts of the current American health care system (variety, heterogeneity, specialization, fragmentation of programs, individualism, fee-for-service, and "freedom of choice") work against an adequate, rational basis for assuring the health of children. Even if every United States resident had the money to pay for a private practitioner, there would not be enough health services to go around, and children's health might not be advanced. Both rural and urban poverty areas suffer from a severe shortage of health services. Those private physicians available to the poor are frequently overburdened and unable to provide an adequate range of services for health maintenance. Between 1949 and 1969 the ratio of physicians to 1,000 children fell 34 percent from .67 to .44 (American Academy of Pediatrics, 1970:98). Beyond the problem of physician availability, Haggerty (1976) and Miller (1976:17) strongly urge attention not only to the nature and distribution of child health services, but to the *assurance* of access; in the words of the latter: "The great need for children's health is not a program that opens the door and awaits the arrival of needy children. The great and crying need in child health is for programs that reach out and involve children who cannot themselves enter the system and on whose behalf no present initiative is exercised to bring them in."

The above discussion brings into focus several important issues concerning the status of child health.

Where the means exist to ameliorate or eradicate health problems, such means do not equitably reach and serve the poor and the nonwhite. Thus, while infectious diseases become decreasingly important as causes of illness and death among the white population, they remain a leading killer of nonwhite children.

When services are provided for the poor, they frequently neglect minimal needs for privacy, dignity, and convenience, thus discouraging their use among those people who most need them.

Conditions which are primarily associated with poverty do not receive the concern and support that other conditions, which may affect fewer children, but affect middle class as well as poor children, receive. As noted, lead poisoning affects more children than did polio before the Salk vaccine, and unlike polio before the Salk vaccine, is a curable disease; yet the government has been unable to commit the necessary funds to eliminate this major crippler of children.

While great strides have been made to decrease the incidence of organic disease phenomena, both mental illness and risks to children deriving from their physical and social environment have been largely ignored and seem to be increasing.

The evidence is unequivocal that poverty and/or membership in a racial minority not only increase the likelihood of a serious or fatal physical or mental health problem, but appear also to compound the negative effects of virtually all conditions which predispose a child to further risk. The problem of low birth weight and its frequently resultant handicap is a case in point. Not only is a poor or nonwhite child more likely to be born premature, but he is more likely than his white, middle-class counterpart of comparable birth weight and gestational age to suffer one or more of the handicaps to which premature birth predisposes him. The next section of this paper presents a detailed examiniation of this aspect of risk in order to illustrate the pervasiveness and complexity of the relationships among risk, handicap, poverty, and race.

The Context of Child Health

Infant Mortality and Morbidity: A Study of One Aspect of the Relationship Between Race, Poverty, and Handicap

Infant Mortality: The Social Class and Ethnic Distribution of Mortality Rates. This century has witnessed a striking decrease in overall infant mortality rates, from 140 deaths per 1,000 live births during the first two decades, to 16.5 deaths per 1,000 live births today. Between 1946 and 1966 the rate reached a plateau (Richmond and Weinberger, 1970) From 1966 to the present, however, there has been a continuing decline in infant mortality. Yet close examination of our infant mortality rates reveals that infant deaths between one month and one year of age are three times as great for our nonwhite as for our white populations, and the gap has actually increased during the past decade (Wegman, 1975). At higher income levels, however, the black infant death rate shows a marked decline and less discrepancy with the white rate. For the black income group between $3,000 and $4,999, the data show a greater rate of infant deaths than for families with incomes under $3,000 (National Center for Health Statistics, 1976a). This might be explained by greater availability of medical care for the "most poor." People with the lowest incomes are eligible for federally funded medical services that the less poor are not eligible for, yet are unable to afford on marginal budgets.

These data suggest that while we are able to provide medical care comparable in quality to other countries, it is our more affluent and generally our white citizens who seem to be benefiting from our increasing knowledge and skill. Infant mortality rates are a revealing indicator of how many of our poor, and particularly our nonwhite, citizens may be excluded from the services our health technology can provide.

Low Birth Weight and Infant Mortality The best indicator of whether or not a baby will survive is birth weight, even when mortality rates are corrected for other important variables such as social class, maternal age, parity, and race (Fort, 1971). Infants weighing 2,500 grams or less (under 5½ pounds) have a neonatal death rate about 22 times the rate for heavier babies, and account for two-thirds of all neonatal deaths (Shapiro et al., 1968).

Morbidity: Social Class and Ethnic Distributions of Birth Weights Since 1950, the distribution of births by weight for white babies has changed little, yet among nonwhite babies the proportion of small-for-date babies has increased markedly. In terms of numbers, low birth weight affects roughly twice as many black as white children (Armstrong, 1972; Niswander and Gordon, 1972). This disparity in birth weight between black and white babies may be more a reflection of the greater proportion of blacks who are poor than of race. Several studies demonstrate that an increase in per capita income is associated with increased birth weights among black infants (Scott et al., 1950; Naeye et al., 1971).

A study of the correlates of low birth weight and infant mortality in New York City demonstrates important relationships between overcrowding and poverty and perinatal risk (Struening et al., 1973).

It appears from the evidence available, that the conditions of poverty, rather than race, may be primarily implicated in depressed birth weights.

Morbidity: Maternal Nutrition, Low Birth Weight, and Subsequent Handicap Perhaps the most important and direct influence on the fetal environment is maternal nutrition. Studies of the effects of wartime nutritional deprivation on birth weights indicate that mean birth weights vary consistently with the nutritional level of the population. The data also suggest that restoration of an adequate maternal diet, even during the last weeks of pregnancy, may be sufficient to overcome the effect on birth weight of severe deficiency earlier in pregnancy (Smith, 1947).

Additionally, nutritional supplements during pregnancy elevate the birth weights of the offspring of economically deprived mothers (Bergner and Susser, 1970). Despite methodological flaws in several of the studies cited by these authors (such as a lack of careful baseline data on previous dietary adequacy, imprecise monitoring of dietary supplementation, and the lack of control populations in many of the studies), the data consistently suggest that improving maternal nutrition, regardless of race, improves the outcome of pregnancy and increases the birth weight of the infant.

Although the evidence supports a relationship between maternal malnutrition and low birth weight, the relation of maternal malnutrition to subsequent functioning of the child is not entirely clear.

Stein et al. (1975), in their followup study of the effects of intrauterine exposure to wartime famine, found that maternal malnutrition per se does not appear directly to contribute to their index of adult mental performance of the children of the famine or to adult health problems. There was, however, a greater than expected frequency of congenital anomalies of the central nervous system.

Although low birth weight is well extablished as accounting for excess mortality in infants, its relationship to child development, both physical and intellectual, as the previous study demonstrates, is not as clear.

Fitzhardinge and Stevens (1972) followed prospectively 96 full-term small-for-date infants to determine the frequency and type of neurological as well as intellectual sequelae. Although major defects were uncommon in this sample, a high prevalence of less severe dysfunction was found relative to a control group of siblings. Roughly twice as many of these children displayed EEG abnormalities than would be expected among apparently normal children. Twenty-five percent showed some sort of speech aberration, as contrasted with 1.5 percent in the United States elementary school population. Average I.Q. was slightly lower for the small-for-date children than for their control siblings. but more important, 50 percent of the boys and 36 percent of the girls had poor school performance. One-third of the children with I.Q. results over 100 were failing consistently in school. The effects of low birth weight were not necessarily dramatic, nor always directly measurable. Rather they were frequently reflected in the "softer" realm of school performance and may be expressed later in their adult roles as providers and parents.

The majority of studies correlating low birth weight (particularly "small-for-date" weight) with later psychological and intellectual development do find low-birth-weight children to be significantly more subject to handicap (Weiner, 1970; Knobloch and Pasamanick, 1966; Harmeling and Jones, 1968).

The strong relationship between low birth weight and poor school performance, independent of I.Q., demonstrates the inadequacy of I.Q. as a unitary measure of intellectual functioning and indicates that the effects of low birth weight on children's functioning may be more subtle and pervasive or of a different quality than intelligence testing can reveal.

The Social Class Distribution of Handicap In addition to the disproportionate incidence of low birth weight among the poor and nonwhite members of our population, one finds that the sequelae of low birth weight are not equivalent among various social classes (Naeye et al., 1971; Niswander and Gordon, 1972; MacMahon et al., 1972).

Not only is the child born into poverty more likely to incur perinatal risk, but the handicapping effects of that risk appear greater than for middle- and upper-class children born with apparently equivalent risk (Illsley, 1967). Biochemical data suggest that major portions of human brain development are left to postnatal life, and that alterations in human brain biochemistry following intrauterine deprivation appear to be recovered with good postnatal care (Chase, 1973). The Kauai longitudinal pregnancy study demonstrates that even severe perinatal stress appears to be compensable in good postnatal environments (Werner et al., 1971). For children from the poorest homes, however, even a moderately low birth weight, between 4½ and 5½ pounds, is likely to be handicapping (Drillien, 1961).

Additionally, the prevalence of perinatal complications appears to be greater among upper-class Negroes than among lower-class whites (MacMahon et al., 1972). This may be due either to differences in the quality of medical care given to blacks of any social class, and/or to the residual effects of a family history of poverty in a newly middle-class family.

In summary, the data suggest: (1) that being poor and/or nonwhite in our society carries with it greater risk of fetal and infant mortality and poor birth outcome; (2) that birth outcome is in large part related to controllable causes; and (3) that the effects of poor birth outcome are intensified by growing up poor.

Children's health and productive functioning are embedded in a social and economic context which can support or inhibit the development and the expression of their innate potential. Fundamental to children's health and functioning is a health system which is sensitive and responsive to the circumstances surrounding the establishment and maintenance of human life.

The Relationship Between Environmental Risk and Functional Potential

The Heredity-Environment Controversy

Among practitioners and scientists in the United States today there is a widespread belief that a child's intelligence as defined by I.Q. tests reliably measures his potential for mature functioning in our economic system. Furthermore, several psychologists and geneticists, most notably Arthur Jensen (1967) and Richard Herrnstein (1971) have posited that, because the genetic determinants of I.Q. are so powerful, environmental manipulation and improvement of health will have little effect in raising the I.Q. of the many children who function below normal levels by this measure of performance.

This controversy has important implications for health planners, as well as for educators and architects of social policy. The following discussion disputes the argument that environment does not importantly affect intelligence and develops a rational philosophic framework for understanding the importance to children's functioning of the environment in which they grow; of the importance of changing those aspects of the environment which impede growth; of what is necessary to support those aspects which nurture growth. In order to make plans for children's health, one must proceed from a fundamental assumption that better care will result in the realization of certain performance objectives, that giving children help makes a difference.

This is not to say that alleviating human suffering is in itself an unworthy reason for providing health service. One may responsibly argue that in a society as affluent as ours, nurturant human services should not have to be justified exclusively on the basis of objective criteria of outcome. There prevails today, however, a philosophy that in a competitive economy, investments in health, or for that matter, in child care, should be returned in increased productivity on the part of children and their families. This objective view must be taken seriously by health providers and planners whose personal ethical and ideologic orientations are essentially compassionate and humane. For as one looks at the data on the suffering of America's children and its developmental consequences, one sees that the present child health structure, which has as its philosophic underpinning the compassionate response to a child with symptoms, is not sufficient to deal with conditions which handicap millions. The authors' discussion is offered to enhance the evolution of a rational public policy on children's health, which might ultimately be more humane than our present one.

Many of the arguments of genetic determinism are persuasive. Studies of monozygotic twins reared apart show that their later I.Q.s correlate more closely with each other than do the I.Q.s of fraternal twins or siblings raised together, and adopted children demonstrate I.Q.s and educational levels which are similar to those of their biological mothers (Jensen, 1967). The correlation between the adopted children's I.Q.s and the educational attainment of their foster mothers, however, is negligible. By contrast, a similar study demonstrates a 20-point gain in the I.Q.s of adopted children over that of their biological mothers (Skodak and Skeels, 1945), and Bronfenbrenner (1976) points out that foster- and adoptive-home placement is not random; that adoptive children are likely to be placed with families whose background is in many ways similar to that of the natural mother.

Whether I.Q. tests are accurate predictors of adult functional potential is open to serious question. Unfortunately, they have been used widely as the major indicator of the effects of programs for disadvantaged children, such as Project Headstart. The heritability argument and unsullied belief in the predictive value of I.Q. measures can be and have been used unscientifically to discredit many efforts towards remediation of the effects of poverty. They support the contention that poverty is inevitable.

If the genetic consequences of years of selective breeding among people of low social class or nonwhite ethnic origin, or "low capacity residue," is considered an inevitable outcome, and if that "residue" largely accounts for membership in present-day lower socioeconomic class, a preponderance of which is nonwhite, certain political and racial implications follow. Efforts to enable poor people to develop the competence with which to achieve access to the goods and services of society, the argument follows, are doomed to fail.

The heredity-environment controversy is a hot issue today. The assumptions underlying it, that intelligence is a quantity, that it is unequally distributed (by nonrandom, genetic determinants), that it can accurately be measured, and that it predicts economic functioning are accepted by many, if not most, teachers, psychologists, physicians, and policy makers. Health planners must address the issue directly. To what extent will efforts to improve the health and quality of the life of our nation's children succeed in making their lives more productive and happy?

Differential Environmental Importance for Intellectual Functioning among the Poor and the Non Poor A major assumption of the genetic determinists is that intelligence is fixed, because of its high hereditary component, and that the hereditary component of intellectual functioning has roughly the same weight for various populations of people. That there is a genetic component to intellectual functioning is not at issue; that it is unrelated and unresponsive to environmental circumstances and environmental change is.

A study of twins from Philadelphia suggests that the relative power of heredity or environment to influence performance might be different among different population groups (Scarr-Salapatek, 1971). On a standard achievement test, scores of black twins were not found to be as similar to each other as the scores of white twins. And among lower income children, the scores of same-sex twins (which would include monozygotic twins who share the same genetic structure) were no more alike than the scores of the opposite-sex twins. Among upper income children of both races, however, the scores of the same-sex twins were more similar to each other than the scores of the opposite-sex twins.

If heredity were the primary determining factor in the test scores, one would expect the identical twin pairs to score more closely together than the non-identical twins, irrespective of environmental factors. It appears from these findings that among middle- and upper-class children, genetic capabilities are more directly expressed in test scores. Therefore children who share the same genetic structure do indeed perform more similarly, when they are *not* economically disadvantaged; the environment exerts more influence in defining the functional potential of poor than of nonpoor children. Bronfenbrenner (1976:141), in a penetrating discussion of the heredity-environment controversy, suggests that performance reflects not simply a given amount of genetic potential, but also the capacity of a given environment to "evoke and nurture the expression of genetic potential." A critical function of his surroundings, then, is to facilitate the development of a child's innate endowment.

The above discussion develops an argument on several levels to demonstrate the importance of environmental factors to the development of children. Poor and nonwhite children are far more likely to be born at significant risk than nonpoor and white children. A financially impoverished environment exaggerates the potential for handicap following that risk. But, a nurturant and supportive environment can permit the natural unfolding of a child's best qualities and capabilities.

The implication of these arguments is that poverty is not an inevitable outcome of genetic selection, as has been claimed (Herrnstein, 1971), and that social policy directed toward the remediation of selected problems associated with poverty is not doomed to fail because of the genetic makeup of that population. This is not to say that poverty is an aggregate of "selected problems," and that giving economically deprived pregnant mothers dietary supplements, for example, will solve the complex processes in our society by which poverty, and its human damage, is perpetuated. Thoughtful health planning as well as other kinds of social planning depends not only on the provision of services in order to ameliorate problems which cause suffering and which can be alleviated, but also with larger public measures which affect the environment, people's prejudices (Cornely, 1976), and the distribution of economic resources.

The Concept of Child Health

The importance to children's health and functioning of the environment underlines the need to understand children's health in a broad context. Health is clearly not simply a matter of Band Aids and patchwork. Health requires prevention; it requires environmental amelioration; it requires ensuring a context which is capable of nurturing and sustaining a child in health as well as in sickness. The concept of child health must include a child's context as well as the child. The concept of intervention should embrace treatment of causes as well as treatment of symptoms.

In this section, the conceptualization of child health will be reexamined, and alternative concepts and their practical expressions offered.

Health and the Ecology of Childhood

An alarming number of children suffer disease and death from environmentally derived causes. The relationship between the environment and morbidity and mortality seems clear when one considers accidents, lead poisoning, child abuse and neglect, failure to thrive, and increased perinatal risk. Additionally a relationship exists between the environment and the occurrence of organic illness, not only in the child but in his family, above and beyond the inadequacy of our health service structure to deliver technical services to the many in need.

Environmental factors which are detrimental to child health can be considered in two conceptual "layers." The first "layer" is that which is most proximal, or most immediately "causal" to a particular disease. Lead paint is the direct cause of lead poisoning; an inflicted injury is the direct cause of child abuse; accessible hazards may be the direct cause of an accident; unfluoridated water causes a high caries rate.

The second layer concerns adult functioning. Our present health structure cannot adequately acknowledge the relation between adult dysfunction and childhood illness, between the needs of families and their relation to children's health. Childhood illness deriving from dilapidated housing (plumbism), overcrowding (infectious disease), inadequate nutrition (iron deficiency anemia, malnutrition, prematurity), or accessible hazards (accidents, poisonings) may be more fundamentally a reflection of parental needs: for employment in order to afford to house and feed a family adequately; for health care for themselves; for help to overcome alcoholism or drug addiction; for family planning; for day care to get some relief from the frustration of spending all day every day in a two-room apartment with four underclothed, underfed, crying preschool children; for adequate transportation in order to get to jobs, services, and day care.

Child Health and Poverty A child has a right to health. This generally accepted principle presents a challenge to the American health care structure. If our health system attends to the ecology of childhood, the relation of a child's life circumstances to his health will lead to an understanding of the need to increase the jobs, goods, and services available to poor people.

Given what we know of the impact of poverty on children's health and life functioning, it is timely to make a principled and strong statement about its relation to the planning of health programs. Poverty, in the United States and elsewhere, appears to cause—directly or indirectly—a great amount of morbidity and mortality in children. Its essentially destructive quality is paid for not only in human suffering, but also in subsequent hospital costs, reduced productivity, drug abuse, and crime.

In present practice, perhaps two-thirds of American children receive what is considered to be adequate health care. The free market economic structure in which health services are distributed leads them to contact reasonably skilled practitioners whose understanding of the subtleties of childhood illness and behavior leads to prompt amelioration of early disease states. Their immunizations are complete, and their nutritional status is adequate.

For the other 25 million children in America who are unable to buy private health care, and who have in addition an increased risk of parental illness and distress, perinatal mishap, and personal illness, health care is provided by a patchwork quilt of categorical programs, entitling some but not all to certain specific services provided by clinics, hospitals, and practitioners. The nature of the commitment of public resources to these programs sustains a concept of the treatment of special classes of illness in special populations. It fails to acknowledge the importance for children's health of the satisfaction of basic needs of all families for the health of all their members, for adequate income, housing, food; of the harmful effects on children's health of environments which lack those basic needs; and of the increased incidence of alcoholism, drug abuse, and adult mental illness in homes where those needs are unable to be met. By entitling only a few members of a family to receive only a certain number of specific services, it militates against comprehensive health care or the prevention of those illnesses (and decreased functioning) of children which derive partly or entirely from illnesses and distress in their family. Childhood tuberculosis, gonorrhea, and psychiatric illness are specific diseases in point.

There have nonetheless been important and encouraging results from such comprehensive programs as the Maternal and Infant Health programs of the Department of Health, Education, and Welfare. Prenatal clinic registrations for the estimated 700,000 mothers eligible rose from fewer than 60,000 in 1965 to around 141,000 in 1971. In Denver, a dramatic fall in infant mortality rate from 34.2/1000 live births in 1964 to 21.5/1000 in 1969 was observed for the 25 census tracts which made up the target area for an M. and I. program. In Birmingham, Alabama, the rate decreased from 25.4 in 1965 to 14.3 in 1969; in Omaha from 33.4 in 1964 to 13.4 in 1969. Similarly dramatic reductions in the percentages of mothers receiving no prenatal care have been achieved by M. and I. programs in Dade County, Florida; Baltimore, Maryland; Cincinnati, Ohio; Greensville, South Carolina; and Atlanta, Georgia (Maternal and Child Health Services, 1971; 1973). The current Administration's inability to sustain—much less to increase—these programs suggests a tragic misdirection of public priorities.

Child Health and the Concept of Diagnosis Both organic and behavioral illness manifest themselves in childhood with less differentiated symptoms than analogous processes in adulthood. Clinical practice usually requires a more or less precise diagnostic formulation before treatment can proceed. Where the understanding of the phenomenon at hand is less than adequate, empiric intervention of an idiosyncratic nature begins. Such is the case with poorly understood organic diseases, such as the hemolyticuremic syndrome and Reye's disease syndrome where the individual case receives the best the individual physician can offer, and with behavioral illness, where the clinician treats on the basis of a personal, abstract formulation of the nature of the individual's problem.

"Diagnosis" in both organic and behavioral situations represents an intellectual effort to integrate signs of illness into a coherent whole. Clinical nomenclature describes groups of manifest symptoms; where little is known, it defines neither pathophysiologic mechanisms nor specific causes of disease.

Illness phenomena in children are frequently complex layerings of increasingly proximal cause. The diagnosis of a childhood illness ought additionally to take into consideration the continuing change of the developing organism. A weakness of the current diagnostic nomenclature is in its neglect of causal and developmental, in favor of manifestational, descriptors of illness phenomena. This is particularly true for the several pediatric symptom groups which seem primarily to derive from "social" or interpersonal causes. These "illnesses" include:

failure to thrive
accidents and ingestions
child abuse and neglect
pica and poisoning with lead-based paint
rumination
excessive bottle feeding (often with iron-deficiency
  anemia as a consequence)
"idiopathic" feeding disorders without demonstrable
  organic cause
"habit" disorders
learning disability
hyperactivity
bronchial asthma

The individual physician's capacity to perceive all of the pertinent information on a given child with poorly differentiated illness is necessarily limited. He is constrained by a mother's ability to observe and accurately report a child's illness data. (Since her own behavior may be a principal cause of her child's symptoms, the information she provides must be elicited skillfully and interpreted critically.) The nature and scope of clinical practice and professional training do not equip the physician to interpret the various psychological and environmental phenomena which operate to produce a particular symptom in an individual child who presents to him at a particular time.

A more causally and developmentally sensitive diagnostic nomenclature is necessary, both to guide the practitioner in sorting through the multiple variables attending illness, and as a conceptual basis for developing a preventively oriented child health care system.

Preventive Services: Early Identification and Amelioration of Risk

The critical quality of childhood is change. A growing human organism is especially vulnerable in his early years. His ability to resist infection and his capacity to fend alone are limited; his nervous system and his ability to operate in an organized way on his environment are constrained by a prolonged period of dependency. As his innate structure matures, he is susceptible to many exogenous influences. To the extent that he is protected from too great physical and psychological risks, the process of growth will lead to his development into a healthy and integrated person.

On the other hand, if risks to his development are not identified and ameliorated early, his growth may be affected adversely and profoundly. The consequences of physical and psychological illness early in life may not become apparent until later. The developing nervous system is especially vulnerable. For example, early infection exerts an important toll in later dysfunction. In regard to his personality, for example, serious parental psychologic disturbance may be associated with later stigmata of childhood behavioral deviancy; violence in the home in early childhood seems to be associated with aggressive behavior in adolescence and adulthood; and early separation or parental loss are associated with an increased risk of psychiatric disability.

A health structure designed to maintain the well-being of children will have to acknowledge the process of change in childhood. The importance of intervening early in illnesses which may present in subtle early forms means that the fundamental concept of the system should be the *prevention* of illness.

Specific services, able to identify early risks and act on them, do not, in general, exist at present in the American health structure. This is partly due to the nature of current medical practice, which is usually limited to episodic contacts during specific illnesses once a child's immunizations are complete. To be sure, as was pointed out earlier, not all American children even receive immunizations. To maintain children's health adequately, a commitment to provide necessary services will have to be made. Their right to health could be assured, with their access to all phases of the health care system a matter of fundamental entitlement. Their potential health problems should be identified early, as detailed below, and an orientation of the system toward assuring their adequate growth and development by preventing illness and its consequences would lead to a different organizational and financial structure for child health services.

Toward Rational Problem-Solving: Screening for Risk and Delivery of Service as a Matter of Right

A more nearly universal care system, with equal access to health services for all the nation's children, would go far to ameliorate the problems and consequences of childhood disease among both rich and poor. Fundamental conceptual changes in the nature of the delivery of health services to children would involve, in addition to entitlement, (1) an ability to understand—and to act on—the relation of a child's environment to his health (e.g., lead-based paint and household hazards); (2) an understanding of child development as a dynamic process where the family-child dyad is the ideal unit of practice; and (3) a capacity to perceive the special process of sampling which leads to an acknowledgment of illness in certain populations but not in others (e.g., psychiatric illness in children of upper-income families is currently more likely to be ascertained and treated than in children of lower-income families, where it may be ignored or regarded as normative behavior; whereas child abuse case reports are virtually only of poor children) (Joint Commission on the Mental Health of Children, 1970; Newberger and Daniel, 1976).

The *screening* of children for risk at certain intervals has been discussed widely; it has never been systematically implemented in America. The Developmental Disabilities Act and the plans for the identification of handicaps in many states give hope for a more effective instrument for sensing needs in childhood and delivering service when it is needed.

The technical methodology of health screening for children is amply discussed in the current medical literature (Frankenburg and Camp, 1975). Although there is no universal agreement on the number of screening studies to be performed at particular levels, nor on the length of the intervals, there is consensus on the need for early recognition when prevention or treatment is most likely to be effective, as well as for the identification of the populations at greatest risk and therefore most likely to benefit from specific procedures. When Title XIX of the Social Security Act was amended in 1967 to make health screening for childhood Medicaid recipients mandatory, it was with a view to encouraging the use of health resources before illnesses became irreversible or chronic.

Whether health screening ought primarily to take place in medical as opposed to other service structures is less a subject of current discussion. For the most part, preschool children in America are not consistently in contact with any institution of society, and it seems logical that whichever component of the service system a preschool child contacts should see to it that his health needs are met.

The fundamental concepts are *entitlement* and *access*; the specific institutional setting in which the need for services is defined is less important. Were all children receiving continuing comprehensive health care (which would include all appropriate techniques for the identification of risks and developmental deviations), then screening per se would not be necessary.

The several options for the site of preventive child health services include the health care system itself, child care institutions, and the welfare structure. Irrespective of where the screening and preventive care for children take place, however, its *universality* is a primary goal. It is likely that the future health care system for children in America will be pluralistic, both in respect to the institutions offering service and the specific populations served. Equal access to high-quality services, and an adequate distribution of resources to all the nation's children cannot simply be assumed: aggressive "outreach" including health education and screening, to those not customarily entitled—the poor, the children of migrants, children in institutions or in foster care, for example—will be necessary.

Health Advocacy as a Technical Method for Realizing Child Health Objectives: The "Social" Illnesses of Childhood as a Model for Action

The Concept of Advocacy Certain illnesses of very young children represent symptoms of severe distress in their families. The seemingly increasing prevalence of these diseases, which have important implications for the later physical and emotional health of these children, has focused much attention about what may be necessary to identify and control them. The question in regard to these "social" illnesses of early childhood has more general implications for child health, and particularly for mental health. It has to do with what we are able to bring ourselves to do for families and children in serious trouble and our capacity to look critically at our professional activities and to acknowledge and act on their limitations.

In the interval between birth and four years of age, the impact of an inadequate nurturing environment is manifested powerfully, if not irreversibly, on a developing child. Certain clinical syndromes present urgent evidence of a major threat to the child's adequate growth, if not to his very survival. These illnesses are childhood accidents and ingestions, pica (or the relentless craving for non-food substances, leading occasionally to poisoning by lead-based paint), failure to thrive, and child abuse and neglect. They are not confined to a particular social class, and they account for a considerable share of early childhood morbidity and mortality in the United States. These illnesses appear to derive from situations of family distress, including poverty, poor housing, illness in one or both parents, marital difficulty, drug dependency, and joblessness. Such distress in a family's life setting seems to affect the parents' realistic perceptions and expectations of their child and their capacity to provide for his needs and to protect him from harm.

Medical and psychiatric treatment for this group of illnesses in childhood often seem to bear no consistent relation to the outcome. There are many reasons for this unfortunate fact, which have to do partly, but not exclusively, with the limitations of professional knowledge and competence. They include public policies toward poor people, among whom these illnesses seem particularly prevalent, an inadequate commitment to provide the services needed to help these unfortunate families, and a curious and regrettable tendency to "blame the victim" if his illness derives from his life circumstances (Ryan, 1971). It seems as though the traditional doctor-patient or therapist-patient relationship is simply not sufficient to affect the causes of these disorders, which may be based less in the parents' personal life-adaptations than in their environments. Families' housing, jobs, and financial and legal worries are not the traditional ground for medical intervention; doctors, psychiatrists, social workers, and nurses do relatively little to effect the kinds of changes which are necessary to prevent recurrence of these illnesses in many of the children at risk and to prevent the serious social sequelae of these early childhood illnesses.

For a professional person to acknowledge this fact means abandoning his strict technical role and applying different methods of intervention to affect the *causes* of distress in a family. A method for helping children and their families, "advocacy," through direct action seeks to intervene to ameliorate causes of family distress.

The concept of advocacy is based on several fundamental principles for personnel and institutions:

1. Non-professional community members are important resources for insight and skill about raising children.
2. Effective child rearing is not necessarily related to educational and economic status. Specifically, the ingenuity and talent required to be a successful parent in the ghetto are different from, and perhaps more important than, the kinds of competence which are represented by professional degrees.
3. Meaningful communication skill related to child rearing and sustaining children's health is related to the professional's ability to perceive and respect cultural diversity in child-rearing practices and values.
4. Health structures, including hospitals, perform their technical tasks more efficiently as the insights, skills, indigenous methods of problem-solving, and modes of communication of the subcultures whom they serve are acknowledged, appreciated, and incorporated into the repertory of preventive and therapeutic techniques.
5. Especially regarding the nurturing of children, but in many other professional encounters as well, the participation of the parent in formulating the plan for his child is a vital ingredient for the success of treatment.
6. In any observational setting, the data are always affected by the instruments of measurement. For the perception of childhood growth phenomena, of the determinants of disordered development, and of the success of intervention, the data are enhanced if observations are made within the cultural setting.
7. In considering technical methods of resolving health problems which derive from qualities of life in the community, it is important to acknowledge at the outset the importance of community participation in defining the methods and goals of interven-

tion. Its humane and ethical significance understood, a meaningful element of input by members of the community strengthens the technical capacity of programs to deliver services and permits the accurate perception of pertinent phenomena of community life which affect the population being served.

Advocacy Methodology: Direct Action

1. Helping families to get what they need to survive and to care optimally for their children, and helping them to become in the future their own advocates.
2. Interceding on their behalf with community service structures, health resources, courts, landlords, and employers.
3. Teaching of age-specific child-development skills, including care (holding, washing, feeding, toileting); play skills (including how to use readily available household items and making simple toys); and social skills.
4. Offering compassionate advice, a sympathetic ear, someone who wants to be called when help is needed, and a mature and competent perspective on what it means to be a parent.

Implications of Advocacy for the Young One would hope that as an effective methodology of intervention for environmentally derived childhood illness is developed, that the community will respond in adapting methods of perception and treatment as well as specialized and unspecialized personnel more appropriately to its needs.

If, as is likely, the important environmental determinants of adult dysfunction, including violent responses to stress and syndromes of mental illness, can be identified in childhood, then fundamental, causal prophylaxis should be possible. Individual approaches to treatment cannot, except indirectly, and for small numbers, identify the primary environmental components which predispose to illness. Epidemiologic methods are better suited for this purpose (Kramer, 1975).

For children, especially, whose personalities are significantly formed by the time they begin school, environmental and familial—as distinct from individual—causes of dysfunction may most efficiently be defined and controlled early. Formal service and educational structures do not—again, except indirectly, as siblings and parents are affected—generally affect a child in the critical years between birth and school. The development of his personality is therefore profoundly affected by whatever quality of life is to be found in his home.

If a preschool child from a troubled family is enrolled early and regularly in a child care setting propitious to his development, he is singularly fortunate. Should there be a catastrophe in his life which leads his family to contact an agency which offers shelter in crisis, a deficit in his development may be perceived and compensated. Regrettably, and especially for infants and toddlers, this is rarely the case.

Home is the natural, logical resource for the successful nurturing of a child. Preventing illnesses, social, psychological and physical, will primarily be accomplished here. The family is likely to remain the archetypal model of child rearing in most human social systems. Identifying the causes of its weaknesses in epidemiologic perspective and developing ways of sustaining its strengths to nurture its individual offspring should contribute initially to our competence to deal with the health needs of children. Ultimately, it should improve our ability to prevent disturbed adult behavior as well.

At the present time, we do not know whether continuing contact with medical structures can make an important impact on a family's competence to parent its offspring. There is, however, evidence to suggest that a medical setting is a favorable entry point for disturbed families who for various reasons resist contact with other service-providing resources. Medical personnel are committed in theory to professional practice which is less "judgmental" than that which one might encounter, say, in court or at school. Medical institutions which offer services to children and families have diverse technical functions, among which are a social role that by tradition is low-key, directly helpful, and unintimidating. So too, should be their advocacy programs. It is said that many traditional institutions, including hospitals, schools, courts, and the military, tend to drive families apart. In a child-advocacy program, continuing contact is both the vehicle to bring parent and child together and the framework to see how certain kinds of helpful intervention make a difference for the child.

Program Recommendations for a Better Health Structure for Children

The ultimate objectives of a child health structure are to prevent lasting dysfunction and to maximize an individual's capacity to lead a productive and rewarding life. For these objectives to be reached, it is necessary to have a system which, for a large population of children, is able to define risks, to identify the means which will compensate these risks, to deliver these services to the individuals in need, and to carry on research and evaluation for the continuous improvement of the programs to sustain health and prevent and treat illness. The five elements of such a structure are the following:

a. Financing measures
b. Planning unit
c. Sensor (screening, evaluation, and surveillance technology)
d. Delivery system
e. Manpower (training, assignment, and supervision)

Financing

Of the $90 billion yearly national expense for health services, about half of the publicly expended dollar and about 35 percent of the privately expended dollar goes for extremely expensive hospital-based services (National Center for Health Statistics, 1976a:42). Many of the latter would not be necessary had childhood services been available to prevent the chronic conditions which hospitals treat.

Measles is a case in point. The findings of the 1971 Immunization Survey have already been mentioned; their cost implications are worthy of mention. In the State of Massachusetts, a Measles Eradication Program began in 1965 (Center for Disease Control . . ., 1972a; 1972b), in which year there were 19,512 reported cases of measles. Estimating the rates of complication of measles and their costs led to a projected saving of $2,076,529 for an investment in health services of $1,312,525.

Similar calculations might be done for diphtheria, whooping cough, salicylate and lead-paint poisoning, and childhood accidents, were current prevalence and control data available (see Schoenbaum et al., 1976). The cost of deviant adult behavior which stems from early childhood neurologic and psychologic risks is impossible to quantify. It is probably enormous, both in terms of medical institutional expense and of the price which society pays for criminal adult behavior. Numerous retrospective studies of adult offenders point to an almost universal background of childhood illness, family crisis, foster care, and early behavioral dysfunction, with few efforts at remediation.

Abstract cost-benefit projections, aside, however, it is likely that there is already enough money within the present child health system to begin a universal comprehensive care structure. The cost is simple to calculate. Assuming 3 million births each year and a $167 expense for each of 16 years of services (Miller, 1976), one arrives at a figure of about $8 billion per year which would begin such a service program for all the children in the United States at this time.

It appears as if the resources necessary for a comprehensive child health program are already being spent (Wallace, 1975). Through a combination of national health insurance, whereby individuals would be enfranchised to receive health services, and the development of a method for allocating sufficient resources for preventive services, the investment could become much more productive. To accomplish these goals, both a national health policy which assures the payment for American citizens' health services and the appropriate distribution of these services will be necessary.

If for political and economic reasons it is not possible to enact national health insurance for the entire population, it would seem sound policy to take an intermediate step with the enactment of a universal health program for mothers and children. This would be analogous to the provision of medical care for the elderly, for which we already have a precedent.

In the light of experience with financing programs like Medicaid, it is essential that national health insurance legislation make provision for an equitable distribution of resources in addition to financing them adequately. Adequate quality of service would be assured, and appropriate incentives provided for the maintenance of health.

Planning

Several options exist for the sites of childhood preventive health services. How they might be built into other services for children (e.g., day care and educational programs) or into health services for adults and families will have to be determined by units close to the population bases served. Not one but several models for child health services will probably evolve in response in local needs.

Just as there is no reason to argue for child health services to be based in one service structure as opposed to another, so too, is it unnecessary to posit a uniform program for the services, so long as they meet certain standards of care.

Where a child health structure independent of the mechanism for providing health services to adults might be preferable in a sparsely populated rural community, for instance, in order more efficiently to find the babies, examine them, and deliver their immunizations, in a particular urban area where drug abuse and venereal disease were major problems, it might be more desirable to integrate child health activities into adult services, the better to acknowledge a family's complex health problems which might impinge on its children.

Available data, previously cited, indicate an increased prevalence of virtually every handicapping condition among poor children. The implication of this fact for preventive health services is obvious: as long as poverty persists, services will have to be more plentiful and intense for the children of the needy.

Because infantile mortality rates are significantly higher in these populations, and with the knowledge, previously cited, that such programs as Maternal and Infant Health Services are indeed effective in lowering infantile mortality, it follows that expansion of these programs, or their equivalent, is logical, as fewer than a fifth of those in need are currently being served (National Council of Organizations for Children and Youth, 1976:45).

If the mechanism for determining the nature of child health programs is to be situated in local units—in order more accurately to tailor the program to the needs of the child population—a basic element in the structure will have to be a way of getting services to the children who might otherwise be deprived of them.

The concept of health advocacy for children has been developed in the previous discussion. By assuring the continuing delivery of service, health conditions which might reduce a child's potential to compete in our economic system would be ameliorated. The right to services would be assured, even if, as seems regrettably likely at the time of the American Bicentennial, the child's right to the goods and resources of society would be a function of his family's wealth or of his ability to fight for them.

Screening, Evaluation, and Surveillance Methodology

An accurate system for the collection, storage, and retrieval of child health information would allow local, state, and national health planners to define needs, develop methods, assign resources, and evaluate their effectiveness in a rational way. Where current information on children's health derives from occasional surveys (e.g., health surveys, hospital case reports, immunization surveys) and from the experience of specific programs which serve portions of the childhood population (e.g., neighborhood health centers, Maternal and Infant and Children and Youth Health programs, etc.), a sensor able accurately to define individual children's health needs and to provide the information to assure that they are met would be an invaluable tool in bringing about an acceptable level of child health in America.

Information stored would be minimal, such as data on immunizations and major illnesses, and the confidentiality of the data would have to be protected assiduously (Hobbs, 1975:161–168). Accurate program planning and evaluation, too, would be enhanced by an information system which allowed a continuing reading of the prevalence of certain conditions in relation to the delivery capacity of the service structure (Institute of Medicine, 1974). The understanding of the distribution of childhood disease which would be possible from such an information system would generate insight into the causes of illness outbreaks and would point the way to their more effective resolution and subsequent prevention.

Delivery System

The hallmarks of an adequate child health care delivery system are listed in outline form as follows:

1. Universal access to health technology
    a. Acknowledgment of the relation between environmental risk and functional potential.
    b. Continuity of screening of all children to ascertain need.
2. Commitment to the use of preventive technology
    a. Advocacy to assure delivery of service
    b. Each service structure to assure that the health needs of children are acknowledged.
3. Child health boards, perhaps as part of such Child Development Councils as recommended by the Joint Commission on the Mental

Health of Children (1970), which would serve as a powerful lobby for the health and welfare of children.

- a. These may be the local counterparts of state 4-C (Community Coordinated Child Care) committees.
- b. Focus on the needs of children in specific areas.
- c. Systematic attention to children's health needs, and assuring their provision, including:

(1) Medical needs:	pregnancy care for mothers
	perinatal care
	primary and backup care
	transportation to sites of care
	school counseling
	psychiatric services
(2) Basic life needs:	housing
	food
	water
	heat
	parental employment and health
	freedom from environmental hazards
(3) Milieu services:	institutional responsiveness
	media regulation
	sex education
	civil rights
	recreation

4. Linkage of child health care planning to the rest of the health care planning nechanism and to other child care services, such as day care, early childhood education, and formal school programs.
    - a. Ultimate integration of human services is desirable in strengthening the integrity of a child's nurturing context.
    - b. A developmental view of child health will lead to a more organized and coherent service system, in that the consequences of childhood illness—and, conversely, the antecedents of adult dysfunction—will be observed and understood; appropriate planning and action will more nearly be possible.
    - c. As experience is being gained with programs for preventing developmental attrition, so commonly seen in young disadvantaged populations, it is becoming more feasible to match appropriate intervention programs to the child and family in need.

Manpower (Training, Assignment, and Supervision)

The development of adequate child health manpower will ideally follow a similarly rational evolution, as will the other elements of the child health structure. Based on a knowledge of the health needs of the children in the American population, and understanding the distribution of illnesses and the variety of methods which are necessary to assure access to preventive and therapeutic services, the needs for various categories of specialized personnel will become apparent.

Some revision of current roles will, to be sure, become necessary. Pediatricians, for example, are already involved in health program planning and administration in significant numbers. The large amount of time which they now spend performing routine technical tasks would be diverted to the treatment of more complex illness problems, the supervision of other technicians, and higher-order conceptual problems of health program planning and management. Their professional training, which now consists almost exclusively of hospital-based clinical practice directed to the diagnosis and treatment of the rare child health problems, will have to be modified to develop their skills as leaders of the child health system.

Nurses, whose talents are largely restricted to the care of the sick child, could with appropriate training become the technical mainstays of the system, as child health nurses and midwives have become in most other parts of the Western world. Under the supervision of physicians, they would assess the development of infants and older children, deliver immunizations and simple treatments, and link more complex cases to more highly specialized personnel and institutions. Silver and McAtee (1975:959) note the importance of developing an appropriate concept of primary health care for nurses in order to "adapt and expand the educational experience its students and graduates receive . . . and better prepare them to meet a greater portion of the total health care needs of the public." With this concept and technical preparation a meaningful sense of role will have to evolve for nurses, who have struggled historically and in current medical organizations to create a profession between the orders of the physician and the needs of the patient (Freidson, 1973:57–69).

Other categories of health manpower which would evolve in a preventive child health program are social workers, advocates, whose backgrounds and roles have been described earlier, and the several categories of personnel whose roles are not easily grouped under one generic classification but who for the most part have high school degrees and varying amounts of specialized technical training. The latter personnel include child health technicians, pediatric associates, and Medexes who perform physician or nurse-assistant functions at several levels of skill and independence, laboratory technicians, child care workers, who frequently have competence in behavioral and development assessment, and lay personnel with administrative and managerial skills.

The training and support of the many elements of child health manpower is a complex matter which will have to be addressed while the implementation of a national child health program is planned and developed. It will require a comprehensive and collaborative effort of training institutions, health care providers, and professional managers. Perhaps more than any other technical task outlined in this document, it will require consummate technical skill, diplomacy, and astute management. Many years of tradition, and a large investment of human energy and real resources, have made our medical and nursing schools and their graduates zealously independent of one another. Getting professional people to work effectively together toward the better health of children in America is a noble and formidable challenge. Doing the job will require the right amounts of money, time, patience, and humor, and a serious commitment to making their work personally and intellectually exciting.

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Senator RIEGLE. I am wondering if we ought to hear at this point from our last panelist. Then we can address questions that any of you might wish to speak to.

STATEMENT OF CAROL PARRY, ADMINISTRATOR, NEW YORK CITY CHILD WELFARE SERVICES, NEW YORK, N.Y.

Ms. PARRY. Thank you very much. I am Carol Parry, and I am the administrator of the New York City Child Welfare Services, which includes as part of my responsibilities child protective services.

I have a feeling that I am part of a very distinguished panel, but I have a very, very different point of view. I would like to talk to you not about research or about how things ought to be done, but about how things really are in one of our Nation's larger urban centers with regard to child abuse and neglect services.

Last year we received 26,000 reports of child abuse and neglect in New York City. We investigated every single one of those reports. Eighty-three children died in New York City as a result of parental acts that we would term as child abusive acts.

In the State of New York two children every week died because of child abuse. Those are facts, not estimates, in terms of what the incidence really is. Those are the facts of what happened.

In some poor areas of New York City, 8 out of 10 children that will be born this year will be reported as an abused and neglected child in the first year of their lives.

I say all of these things to give you some idea of the magnitude of the problem we face in a city like New York

And then I would like to give you some idea of where our money goes that we spend on children's services in the city. We spend about $22 million a year on our child protective service program. That translates almost exclusively into an investigatory process. We have a very good reporting system and we investigate the reports, but what we are not able to do is to stem the flow of reports in, or to treat the cases when we get them.

We spend about $240 million in the city on foster case services so that we can take children away from their families and provide them with some kind of safe haven. About half of these children initially come to us as neglected and abused children. Then we spend a pittance, about $1 million on treatment programs for abusing parents and children and about $5 million on services to prevent child abuse and neglect.

Senator RIEGLE. Let me stop you for a minute. Did I understand your first figure, the foster care figure, did I understand you correctly to say $240 million?

Ms. PARRY. That is correct.

Senator RIEGLE. A quarter of a billion dollars?

Ms. PARRY. We have 30,000 children in foster care any day of the year in New York City. It costs us $240 million a year to support those children out of their own homes, while the money we spend either in investigating child abuse or treating child abuse, if you add up everything else we are doing, probably comes to less than $30 million, and this is a clear result of Federal funding priorities, where the open ended money has been and the general attitude in this country, which is that you treat the problem, be it mental illness, physical illness, criminal behavior, or child abuse, by removing the problem from the community. You remove the child from the family and put the child in foster care, therefore the child is safe. You haven't solved the problem, you haven't helped the family and in the long term you have probably done considerable damage to the child.

That is our major concern here, that I believe that our experience with the act has been very, very disappointing. We supported this act in 1973. We wanted it. We thought it would be particularly helpful to large communities like ours where we had limited funding opportunities. We were locked into certain service patterns like enormous numbers of children in foster care, but what the reality has turned out to be is that the City of New York itself has received no money under this act. We haven't even received any technical assistance that has been available through the various regional centers or through the national office. In fact, the impact on us has been just about zero. We did submit a proposal in 1975 for a comprehensive treatment program in the south Bronx in New York City for about a million dollars. That proposal was rejected by the National Center. That was the one and only opportunity as a public agency that we had to apply for these funds. We had not been invited to apply in any other instance but that one year. So what it has come down to is we have the children, we are facing the problem every day, an enormous number, tens of thousands of children being abused and neglected, but we don't have any of the resources we really need to deal with the problem.

I would like to get on very quickly to my recommendations regarding the act. First, we think that the priorities in the act are wrong. I couldn't agree more that I would like to know more about why parents abuse their children, how large the problem is, why it is that we aren't identifying middle-class parents, and we are primarily dealing with minority and low income parents, and so forth, but for somebody that is literally in the middle of the battle all of the time, what I would like to see is much more emphasis on preventive services and treatment services. I think we have done a terrific job of identification in this country so far and I agree with some of the previous comments. In fact, I think some of the definitions of neglect under our State laws and under various model national laws are so broad that virtually every parent in this country could be determined to be a neglectful parent sometimes or other if we really wanted to use the laws that way, but the real issue is what do we do when we find these people and what do we do with the children when we find they have been abused or maltreated, and the answer is—and the answer is true in every big city in the country—the answer is we are doing nothing.

We are dealing in New York City in treatment services, with about 250 children at any given time. We estimate that we have about 10,000 children on our caseload at any time that could use—they and their parents—treatment services.

What would this cost us to do it? It would probably cost us something between $25 million and $30 million in New York City.

What would we settle for? We would settle for anything that would begin to give the public agency, the agency with the frontline responsibility, some resources to develop real treatment services for parents.

We are tired, I can tell you that, of being the agency that is known as the child snatchers in this country, and you know the reason we are called child snatchers is we don't really have any other option. A child is in danger, we take that child from his parents. What we would really like is the option to keep that child at home or to put the parents and the child into a treatment program or put the child into a therapeutic day care program and the parents into a therapeutic program, but that isn't available to us.

Our proposal for the south Bronx was for $1 million. That is not a lot for the city of New York, even with a total allocation for the country of $20 million. Generally we are considered to have 10 percent of the problem, whatever the problem happens to be in social terms in this country. If we could begin, and that is what I thought the purpose of the act was—to help us begin to develop things that then could foster additional funding and support from some of the ongoing sources, title IV–B or title XX—we could at least begin and show what can be done, that a public agency could be credible.

We have reached many, many more clients than any of these other little programs that have been funded all over the country. I think that would be a very, very good start, so my first recommendation is that the bill itself should emphasize services, it should emphasize things like crisis nurseries, therapeutic day services, group therapy for parents, day care and parent education programs.

I think that we can again figure out that certain kinds of parents, by their behavior, are likely to become abusive and neglectful parents, but we know for sure the adolescent parent is the most likely parent to be abusive. The poor little teenage girl who has a child simply does not know what to do with the child. She has not been educated on how to raise a child, how to provide sustenance and support for the child.

The second recommendation I have has to do with the distribution of funds. I feel that large public agencies, be they State or local agencies, as long as they are direct service providers, should be the primary recipients of funds under this act.

As I said, we are on the frontline. We have the children and we have the resources. The funds that are available in general should be channeled through the designated State and local protective service agencies so that we can determine what the priorities are in our communities, not what someone that sits in Washington reads as to proposals that sound good, the proposals, which I have to tell you, that came out of other New York City entities than the city department. Proposals which we drafted, which we supported and after they were funded then the agency came to us for technical assistance because they didn't know what to do.

Senator RIEGLE. I take that to mean that some private agencies in New York did receive some money.

Ms. **Parry**. One private agency received funds in New York City and one university in the State received substantial amounts of funds as a research center. In both instances we in fact were the moving force because as a public agency we see that as part of our responsibility to help people interested in the area to guide and assist them, but they were not experienced in this field. They didn't know where the problem was. They couldn't set the priorities. We are the child protective service agency; we know where the kids are, we know who the families are and we know where the services ought to be delivered, so what I encourage you to do is require these funds be channeled through the mandated protective service agency, not that we get it all, but that we have a heck of a lot to say about who gets it and why in our communities.

Finally, regardless of the extension of the act, regretfully I have to recommend that the act only be extended for a year and that during that year some very hard looking be taken at how the money is being used, what benefits can be gained out of it, how decisions are being made in terms of who gets what under this act and, finally, that this be incorporated in the overall look at the reorganization of children's services that is about to go on or is going on in HEW.

I think the fact we have a National Center on Child Abuse in one place and a foster care program in another place and we have a day care program someplace else and child health program someplace else and all of that is a good piece of our problem nationally, so I would like to see the act extended for the purpose of examining what can be done within the context of the act, but also in terms of where this program should fit in a comprehensive children's services program in HEW.

Thank you.

Senator **Riegle**. Thank you very much for your testimony.

You indicate that there are at least 10,000 youngsters that need help at any given time and that you are able to treat about 250, basically, in terms of any sort of basic treatment?

Ms. **Parry**. That is right, in terms of what we would call a treatment program. We are able to remove a substantial number of that 10,000 from their homes and put them in foster care. That's easy.

Senator **Riegle**. But that is really a different thing and in that area you are spending $240 million a year, which, to me, is just an absolutely mind-boggling figure. Are you aware of any place or have any demonstration grants been made to any large sort of frontline social service operations like your own in some other city where they had the money made available to try to do what you are recommending here?

Ms. **Parry**. There have been a handful of grants. My colleague here is telling me there is one in Union City, N.J., that has been given to frontline agencies.

Senator **Riegle**. Do you have any sense for how that has worked out?

Dr. **Kempe**. Colorado has such a grant. I am very impressed with it, with what it did. It got a little money, something like $85,000 to $100,000 on top of an existing budget which was inadequate and it was able to add to the existing textbook structure those parts of the total treatment program that the county previously was unable to provide and they went from what I would consider a 1925 model of child protective service to a 1977 model by providing what I think is the whole range of services, with very little money and very effectively and I might say, Senator, since that program went into effect we have not had a death in Adams County, when we always previously used to have four or five a year, so I do think there are times and ways to assess that and I think that what we would like to avoid really is simply putting more money into a system that isn't working. If we in fact use the money in a way that will allow the kind of innovative programs that the previous speaker referred to, then I am all for that. I am against simply multiplying a single discipline, single treatment set up and in that sense I think the model does exist.

Senator RIEGLE. You indicated that the city was only asked to apply for funds under the act once. Do you have to be asked or are you not free to take the initiative?

Ms. PARRY. The way the Center is operated is they request proposals for particular kinds of programs and for particular purposes and we have had one opportunity in 1975.

Senator RIEGLE. So your understanding would be that you are not free to come along the next year and just ask?

Ms. PARRY. Not unless public agencies are considered one of the priority agencies.

Senator RIEGLE. Senator Hayakawa, do you have any questions at this point?

Senator HAYAKAWA. I am grateful to Ms. Parry for her deeply felt and eloquent statement on behalf of the special services department in New York City.

As I understand the testimony of Dr. Newberger and you, Ms. Parry, you really have different emphasis. Dr. Newberger, you are really in the origin, the etiology, the causation, and you really want basic research done in this area and you want funds set aside for that purpose?

Dr. NEWBERGER. Yes, sir, that is correct.

Senator HAYAKAWA. This is a problem that really has not had adequate research, in your opinion?

Dr. NEWBERGER. I would share Dr. Zigler's view that there are very few substantive studies which can guide an effective medical practice. The problems in the child welfare area derive in large part from the illusion that child abuse and neglect are poor people's problems. They are not. But problems which are identified as poor people's problems in this country, and especially in New York City, tend not to get the resources and tend not to attract excellence and continuity and permanency of professional people. I think that this has largely to do with why we are in the situation we are in today with child abuse and neglect and why things are the way Ms. Parry says they are New York. If we saw the neglect and abuse of children in the homes of the more affluent families, I rather suspect we would not have the awful struggle we have to get services to keep families together, with so many children placed unnecessarily in foster homes.

Senator **Hayakawa**. What are the directions in which this kind of research into child abuse would go then? Would there be, for example—I am very curious about this—would there be comparative studies of what is defined as child abuse, let's say, in France or Japan or Russia as compared to what is done here? Would there be data on that?

Dr. **Newberger**. There have been some comparative studies, Senator, on child abuse in different cultures and I think these studies in some ways are helpful and fruitful. My feeling is, however, that so long as we characterize the problems that we are studying as child abuse and neglect, and focus our attention only on these problems, we are going to be unable to avoid the preferential selection of those socially marginal families that get these onerous and value-laden diagnostic labels. I am concerned that nearly all the studies of child abuse and neglect treat only those cases which come to light through the existing processes of diagnostic and reporting. We tend systematically not to look at the wider range of family problems.

Senator **Hayakawa**. These things you call accidents, which disguises a great deal?

Dr. **Newberger**. That is right, but I think, too, it is well to not limit our attention to what we call child abuse in individual homes. I think it is very important, for example, to consider the sexual abuse of children as part of this problem. This has not been a matter of emphasis on anyone's testimony today. My feeling is also, that it is very important to look at what makes families strong, lest we conclude, for example, that any family that is poor is automatically a family where there is risk and where, for example, a case report ought to be made and perhaps the child separated from its parents. We need better to understand what it is that militates for family strength and the ability to protect the child in families during times of stress. I think it is better to base our professional work on concepts of competency and strength in children and parents, rather than incompetence or disease. These names, unfortunately, connote deviancy to clinicians and to the public. They suggest that these are sick families and that their children ought to be taken away from them.

Senator **Hayakawa**. Of course you haven't got a vocabulary for this whole field. I mean the terms child abuse and neglect have value connotations that are critical of the parents.

Dr. **Newberger**. That is exactly right. On the other hand we have the name accident where the notion of cause and effect is without value connotation. We need a better classification scheme, I agree.

Senator **Hayakawa**. I understand Ms. Parry at the very frontline is concerned with these matters and with enormous urgency about treatment. I would like to ask another question about some of the things you said, Ms. Parry. You said the incidence of what we will just call for the time being child abuse and neglect occurs very often in teenage mothers who really are not trained for their responsibility. Would you like to expand on that a bit? Is this often the case, that they are unmarried mothers, too, and so on?

Ms. **Parry.** Yes. I think my colleagues would agree with me on this, that we find that young mothers, particularly teenage mothers, often unwed mothers or single parent situations, tend to be more neglectful of their children than individuals who have been better trained and have had more adequate home life, role models and so forth, in terms of caring for children. These young mothers tend to be more neglectful and they simply have not received adequate parental training. They just don't know what to do with babies or how to care for them or even what their own responsibilities or actions or emotions are with regard to these children. You see a 13 year-old with a baby and it is hard to distinguish who is the child in that relationship.

Senator **Hayakawa.** You have no program in New York such as we have in San Francisco where high school girls can bring their babies to school with them?

Ms. **Parry.** We have some. I don't want to indicate there is a dearth of things in New York City. In fact, in many ways we tend to be more sophisticated, as you know, than other parts of the country in providing social services, but the problems and numbers of individuals involved in those problems are so enormous in the city. There are programs, specialized programs for unwed teenage mothers and there are special schools for these mothers. There are mother-child living arrangements which we fund in order to help these mothers get off the ground in the first few months after they have their babies, but they can only touch a very few children and young mothers in terms of the total.

Senator **Hayakawa.** If you had the opportunity to request a specific research from Dr. Newberger, what would you ask? I mean, obviously, some kind of research would be helpful.

Ms. **Parry.** Right. Well, I think from where I sit the most helpful research would be one that related the causative factors—in other words, what is it that makes a parent abuse or neglect the child, abuse, particularly, because neglect tends to be much more environmental related, as I said before. I think we should understand, when we talk about child abuse, we mean physical abuse of the child and when we talk of negligence, we mean inadequate housing, clothing, the child not going to school and being unsupervised and so forth.

Senator **Riegle.** Might I stop you for just 1 minute? I notice that the definition does seem to sort of focus specifically on physical abuse as opposed to emotional abuse, yelling at the child or something else short of actual physical hurt. I would be concerned that the emotional beatings and traumas in many cases could be as bad or even worse sometimes than the physical.

Ms. **Parry.** You are absolutely right about that. The difficulty we have is in diagnosing that and proving it. We are dealing with a legal problem here in which we are labeling parents under the law and through the court as having created a kind of minicrime against their children, so there is emotional neglect, no question about that, and emotional abuse, but you will rarely find cases where that is proven. I think that is the kind of neglect that we would find much, much more in the middle class if we were really getting to these families, but what becomes public and what we tend to view as abuse is the kind of horror tales like the one that came across my desk yesterday where a parent held the hands of a 10-year-old child in an open fire to the point where the child is in the hospital now with third-degree burns and the parents are in jail.

When we got the call, we went out and took the child away and put the child in the hospital, but I could sit here and tell you horror tale after horror tale that goes on. Those are the things that tend to shock us when we focus on it.

What I was saying is in the best of all possible worlds, I would like the research to begin to tell me enough about why parents are doing what they do and some of it is environmental. I don't need research to tell me the people that live in a house where there are rats and roaches all over the place are going to have a lot of trouble raising their kids in decent environments, but I would like to know what kind of treatment programs are going to be effective in dealing with the basic problems. That is a good deal of what has been said here. We do not know a lot about why parents do these things to their children. We know a lot of things that feed into it, but we haven't been able to treat it like you might treat appendicitis. You diagnose the problem and you know what the cure is there. However, this is a much, much less defined area.

Senator HAYAKAWA. Mr. Chairman, thank you. It doesn't seem to me you can get at the matter of emotional abuse of children because when, let's say, an overpossessive mother emotionally cripples her child she always does it in a very gentle way, and it isn't a police matter.

Ms. PARRY. That is right, and if you are in the middle class, you probably end up with a psychiatrist and, hopefully, the mother ends up there, also.

Senator RIEGLE. It seems to me that that is exactly right. The direction we are heading in accumulating this understanding, once we get on top of the physical abuse problem—which is so overt and the kind of thing which this has been attention focused for a long time and borders on criminal acts, or in some cases would in fact be a criminal act—is to focus on what is happening to youngsters and what goes on in these relationships and how are people damaged; it is not just whether a bone is broken or whether somebody's spirit is broken in some other fashion.

Ms. PARRY. I think there was some reference in earlier testimony that we know abused children have a tendency to grow up to be abusing parents and if children are exposed to violence in early family life, they grow up to be violent adults.

Senator HAYAKAWA. I want to thank the witness very much. I am sorry that I didn't get here earlier to hear the rest of the testimony. I am going to go help California agriculture now.

Senator RIEGLE. I would like to add that while you are at it, I hope you try to save Michigan agriculture.

The committee has some questions that we would like to ask each of you, if you would, to respond to for the record because there are some things that we think would help us clarify what we ought to best do in terms of possible changes here. So if I may, I am going to ask each of you if you would be willing to respond to a very short number of specific questions for the record.

I am not going to ask additional questions then at this point. I might say before this panel leaves the table, however, how deeply grateful I am and I know Senator Cranston is and the committee is to have you come and present this kind of testimony to us because the oversight function can only be done through some composite of the kind of very forthright observations that you have all been willing to share with us today. So it will be a great help to us.

I might also say that following you at the witness table we have two parents who have agreed to testify, who lived through the stresses and strains of this kind of pressure and experience and who have been gracious enough to consent to come here today to give us their reflections from that vantage point. So in excusing you from the table I want to again thank you and I also want to invite our next witnesses up. We would love to hear from them.

As I understand it, Benet and Beverly are both here. Why don't you come up and just take a seat at the table.

Benet. We are coming up separately.

Senator **Riegle.** All right, fine. Are you Benet?

Benet. I am Benet.

Senator **Riegle.** As I understand the arrangement, we are just going to hear your thoughts and reflections on what this experience has been like for you in terms of your own child-bearing and child-rearing experiences.

Why don't you go ahead and give us whatever statement you would like. Take whatever time you want to for it.

I am very grateful that you have consented to come because life is tough enough without having to discuss it in public, but it is so important that we have the chance to hear some of your thoughts that we are very grateful to you for having the courage and kindness to come and meet with us today. So why don't you go ahead?

STATEMENT OF BENET, CHILD ABUSIVE PARENT REPRESENTATIVE

Benet. My name is Benet and I am a child abusive parent and I just wanted to talk about some of the things that led up to this.

I have two children, a daughter 4 and a son 2½. They are both hyperactive children. If anybody knows what a hyperactive child is, they can't sit still for more than 2 to 3 minutes at a time. They are just constantly everywhere. It was wintertime and we had been in the house for like months at a time and they had been at the stage of screaming and crying and fighting with each other for about 3 hours constantly and I got to the point where if they didn't shut up I was just going to knock them up against the wall. I had been to this point a couple times and I had spanked them or smacked them and hit them a couple times, but nothing to any great deal and I got to the point that if I didn't do something I was going to bash them against the wall, so I called the protective services in Arlington County. I talked to some of my friends about an hour and they gave me a social worker and she came out and assessed it and the children were put in protective custody for about 2 or 3 days, until I could get myself together.

After they came home, I was given group therapy. I go in on every Thursday for my 2 to 3 hours with a group of parents and we discuss why we feel the way we do toward our children. I mean the guilt that you have when you do something like this to a child is just unreal because they can't help what they are doing, but you can't help the way you feel either.

I know Mr. Zigler was talking about why parents are more prone to abuse premature children. Both of my children were several months premature and I think a lot of it has to do with separation because the children were born and you don't see them and they are put directly into a premature nursery and you leave the hospital without the children and then 2 or 3 weeks later the hospital says you can take them home and you know you don't even know who this child is, except it has a name and it is yours and it comes home and you have problems because it is slow. People say well, my kid is doing this; what is yours doing. "Oh, it is not doing that."

They are just slow to develop and I think people judge the parents and not the child; she is a bad mother, and the mother, in turn, takes it out on the child.

I think that is about it, really.

Senator **Riegle**. Let me ask you, if I can, a little bit more about the circumstances with your two youngsters. Can you describe a little more fully your family situation?

Benet. My husband is military. He is in the Navy. He will be going overseas. He works 12½ hours a day, 4 days a week. He has 4 days off where he works another part-time job so we can make ends meet and he comes home 7 or 8 o'clock at night and the kids are already in bed. They never see their father. They really don't know who he is.

Senator **Riegle**. At the time of the real buildup of tension, was that the pattern then? Was he just not available to give you a hand?

Benet. Right; he didn't realize exactly what was going on at home.

Senator **Riegle**. So you felt you sort of had to field it pretty much by yourself?

Benet. Yes; like everything is going on me.

Senator **Riegle**. Is your family in the area or do you have any brothers and sisters?

Benet. My parents live in the area and they are both senior citizens and they can't cope with the kids.

Senator **Riegle**. So that wasn't a place you could turn to for help? There wasn't any other family help for you, basically, is what you are saying.

Benet. No; there wasn't.

Senator **Riegle**. The fact that your husband works these part-time jobs and so forth, I gather that the economic pressures must cause him to do those extra jobs.

Benet. Right.

Senator **Riegle**. Is that sort of a strain for you?

Benet. We are not really poverty or we are not middle class either; we are just stuck in the middle. We are not eligible for welfare and yet we are not making a great deal of money either.

Senator **Riegle**. How old were you when your first child was born?

Benet. Twenty-two, but I had given one up for adoption, like when I was 17, so it was really my second child.

Senator **Riegle.** I think it is vital that you indicate why you felt it was important to come to the committee and why you wanted to do so.

Benet. I feel that if the money were not given to these services there are going to be a lot more mothers that are in the situation I was in. I was fortunate and I knew who to call, but especially in a military situation.

Senator **Riegle.** So when the pressures got to the point where they were sort of unbearable, if you didn't have a place to turn for help, as you did have in your instance, what you are saying is that those would just be uncontrollable urges at some point?

Benet. Oh, yes, definitely. I mean I wouldn't have thought twice about doing it, unfortunately.

Senator **Riegle.** In terms of what you have learned in the parents anonymous group that you go to—is that what it is called?

Benet. No; this is called Pro Child. I guess it is affiliated with Parents Anonymous.

Senator **Riegle.** What are you learning there that is helping you deal with these pressures that you feel?

Benet. That I am not alone in what I feel, that there are other people that feel the same way I do. Like I know when I get to the point where I just want to throw up the towel I can call them and they will put them in a baby center for awhile, or if I want, for a couple days I can put them in foster care, but so far I haven't used them, but I have been tempted.

Senator **Riegle.** When you think about the question of child abuse and how it can be prevented, what thoughts do you have in mind in terms of what you have learned and what you felt yourself? What do you think the best way is to try to keep this from happening, not just in yourself, but in other people?

Benet. I feel that any parent is a potential child abuser. Every parent has a point or a limit to what they can take. It is how they deal with it when they hit the breaking point. If they need help, they should call. A lot of people can deal with it, but a lot of people can't.

Senator **Riegle.** Do you feel, just in terms of getting prepared as a parent, just in the things you have learned at school and learned at home and so forth to get ready to have children and to care for children, do you feel that you have the kind of insight along the way that——

Benet. To a certain extent, but like they can only give you the basis. They can't give you the individual situations. You know like there might be a child that has a particular problem. They can't give you the depth that you need maybe to handle that situation, but I think it would be beneficial for a parent to know what they are getting into before they have kids.

Senator **Riegle.** I can imagine that having two hyperactive children at such a young age that that is a lot to cope with, even if everything else in your life was perfect, and I am sure it wasn't.

Senator Cranston is here and I am sure he has some questions he would like to pose.

Senator **Cranston**. Senator Riegle, first I want to thank you very much for chairing the subcommittee this morning. It has been most helpful and I know it has gone on very well. I am very grateful to you.

Have you personally seen instances of child abuse in other families or has there been a history of child abuse in your family?

Benet. I have seen cases of child abuse; yes. Three of the people that I have been dealing with are also personal friends and, you know, it is not very pretty.

Senator **Cranston**. Have there been any instances in your own family?

Benet. No; I was the first one.

Senator **Cranston**. Do you think child abuse can be prevented and, if so, how?

Benet. I don't know whether it can be prevented because you have to first do it. I don't think it can be prevented, but you can help the parents after it has been done.

Senator **Cranston**. What do you think the best ways are to deal with the problem when it does occur?

Benet. To give the parents counseling and to help them deal with their emotions and handle the guilt for what they have done with the children and to help them to realize that they don't have to be this way, that, you know, they don't have to take it out on the kids, that there are other ways that they can deal with their frustrations.

Senator **Cranston**. Is there anything that needs to be done for the child at that time?

Benet. I don't think, unless it is really big, that the child should be taken out of the home because that even makes the parent, when they get them back, even more, I think, prone to abuse. I think the child should be left in the home if at all possible because I know when I got my kids back I was just overwhelmed because they wanted to know why did you leave me with these people, why didn't you come and get me, don't you love me any more and then the pressure that I was getting from my own family.

Senator **Cranston**. Thank you very much.

Senator **Riegle**. We are very appreciative of the fact that you are willing to come today and talk about things that aren't easy for you to talk about. It is very helpful to us that you are willing to do that and I think it puts us in a position to use your thoughts and insight to help other people and help other youngsters. So it is very special, the fact you were willing to do it.

Senator **Cranston**. You were really great to come. Thank you.

Are you our second witness?

Beverly. Right, I am Beverly.

Senator **Riegle**. We appreciate your coming and, as I was saying earlier and as you heard me say, I know talking about these things isn't an easy thing to do, but it is important, and Senator Cranston and I appreciate the fact you were willing to come. Why don't you tell us your story in terms of the things that have happened that you think would be useful for us to know here.

STATEMENT OF BEVERLY, CHILD ABUSIVE PARENT REPRESENTATIVE

Beverly. OK. I, too, am an abusive parent. I abused my son physically when he was the age of 5. It was pretty bad. He had to be put in the hospital and placed on the critical list.

It is a long story, but I will just say from there he was placed in a foster home, which will be 4 years in May. I would like to say at the time my son was in the home—first of all, he was an unwanted pregnancy. I did not get an abortion for the simple reason I had an illegal abortion before and the result of that was almost death, so I was afraid to get an abortion. Also, my husband did not want me to get an abortion and before the baby was born my husband had walked out on me. We had been evicted and I had no place to go. I have no family, so in the meantime I had to, you know, walk around and try to find a place for me and my other three kids.

Eventually I did find a place and when I moved there, and without having any food and whatever and I had applied for welfare, but had not received any assistance from welfare.

When I went to the hospital and gave birth to my son, for 2 days I did not want the baby. When the nurse would come to me I would say I didn't want the baby. She would ask me why. I couldn't give her a reason. All I could do is shake and shake and I was frightened, so on the third time I went ahead and took the baby for the simple reason the nurse was getting upset with me because I would not feed the baby. I did not want to take my baby home, but you just don't walk around telling people, well, I don't want this baby, so I thought I could deal with it. I had to stay in the hospital a little longer than usual because I had no one to come get me.

Finally, someone did come. I took my baby home in hospital clothes and I dealt with it the best way I could. Before my son became a year old, my husband had returned back into the home and from the day that he walked back into the home it was a constant argument about my son. Every day it was the same thing, day in, day out, about you hate him, you hate your son, you hate him, you don't do this and you are not doing that or whatever.

In the meantime I had gotten a pretty good job working in one of the hospitals and every day my husband would call me on the job and tell me that my son wasn't getting proper care and my daughter wasn't doing this and she wasn't feeding him and it was just a constant argument all of the time when he would pick me up. When we went to work in the morning it was the same thing and when we went home it was the same thing. My job was as a supervisor and I was under a lot of pressure. In the meantime I became pregnant with my youngest child and that forced me to quit my job. Therefore, I was in the home 365 days a year, 24 hours a day. My husband felt as long as he was out working and made the money and paid the bills that I was responsible for the discipline and everything. I was under a lot of pressure for the personal things that went on in my home. My oldest daughter, she is not his daughter—my husband is not her father—they were at each other all the time. I was trying to keep peace in the family. I had no privacy. I remember going into the bathroom one time to try to be by myself, which was totally impossible.

I remember in 1973 when the abuse occurred, I remember saying to my husband, I said something is wrong with me and I said, "I can't stand this house, I need to get out, I feel like I am going to scream."

He said, "Well, if you start screaming and hollering you will be OK."

I think a couple days before that I was sitting in the bedroom and I said to myself—all the time you just want to talk to someone because you know you just don't do this—who are you going to talk to. I was sitting in the bedroom and I said, "Well, I need to go see a doctor. What doctor am I going to see?"

I was afraid if I went to a doctor my kids would be taken from me. At the same time I was saying to myself I am either going to kill myself or hurt him so bad he is just going to have to be put in the hospital, and about a couple days later it happened. I had picked up a hairbrush and hit him in the head and as a result of that abuse I was arrested at the hospital and locked up and I was charged in civil and criminal court. In civil court I was charged with neglect and in criminal court I was charged with simple assault. I was given 2 years probation and the court ordered me to a forensic psychiatrist. I attended the therapy group for 2 years, until 1975. I left that group and went back home.

While I was at home I became very depressed. I didn't know why and for 6 weeks I did not answer my phone, my door, or anything. Every second Saturday of the month I visited my son, so when I did not call my social worker to let her know whether or not I wanted to see my son, she had not heard from me for 6 weeks, so she called me, so that one particular morning I decided to answer the telephone and it was her. She said she was very concerned about me because she had not heard from me and a lot of weeks I wouldn't answer the phone, but this had been the longest time. She said that she was very concerned about me when she hadn't heard from me and she said, "I sent you a letter." She asked me what was the problem and I didn't want to talk about it.

I said, "Well, if you think I will harm my kid, I will bring him downtown so you can see him," because it is very hard for me to believe that anyone could care about me and I just thought that she thought that I had hurt my kid, but she said, "No, it is not that; I know the kids are all right; it is you I am concerned about," so I told her I was OK, so the next morning the lady that was my social worker from the therapy group and forensic psychiatrist, she came by and knocked on my door at 9 o'clock in the morning and I let her in. I talked with her for about 2 hours and in talking to her I felt pretty good, just talking to someone that I thought cared about me.

In the meantime I am going to Parents Anonymous, the group I am in now that I go every Thursday to, and I looked forward to it. The social worker was about to leave town and she came back to my house and talked to me about trying to form some type of Parents

Anonymous group for the District of Columbia and not ever believing I could do anything or anyone would ever listen to me, you know—who am I, you know—and I told her I didn't think I could do it, and she convinced me along with one other parent, so we sat down and we talked about it and our sponsor, Mrs. Graham, a social worker down at the Protective Service, that particular night was to come to my house for the meeting, but somehow or another she didn't make it, so on that note, the other parent and myself got together and said, well, she didn't show up at the house and maybe we just better drop it, so I think it must have been about a couple or 3 days later the other parent called me and asked what are we going to do, and I said, "Well, I am not going to call," and she said, "Why not," and I said, "Well, she won't hang the phone up in my face," and she said, "Well, the only thing she could do is say yes or no," so we contacted Mrs. Graham and she jumped at the chance and we held the meeting in August 1976, and we have had Parent Anonymous since. We got started in 1976. Although we are not funded, I just use my home phone as a hot line and I am there 24 hours a day, which I find very gratifying because I have a lot of parents that call and Parents Anonymous is a group of parents that get together who can relate to one another, who have problems that they would like to share with other people that they can relate to.

Senator RIEGLE. Let me just interrupt for a minute.

I just want to say again how much I appreciate the fact that you are willing to come and talk about these things and help us understand and help put us in your shoes so we can really feel the kind of pressure that you were feeling at the time. You really helped us a great deal by how well you described the situation, and I am grateful for that.

I have to excuse myself now because I have to be over to open up this session of the Senate today. I would very much like to stay because I wanted to talk with you more about it, but I know Senator Cranston will have some questions that he will want to ask that both of us will be interested in.

In excusing myself, I want to again thank you for coming and helping us grapple with this problem, which isn't just your problem, but is our problem and everybody's problem.

Senator CRANSTON. Thank you.

Do you want to go ahead?

BEVERLY. We have seven members in Parents Anonymous who attend each and every Thursday. I guess that is just about it. What we are really trying to do is perhaps get some type of funds where we could get transportation for the parents, funds for babysitting and for some type of parent classes because I think that is very important to have some type of parent classes, especially for the younger mothers.

I think I have covered it.

Senator CRANSTON. You are really wonderful to have come here to talk this openly and, second, to be doing what you are doing to help other people that have the same sort of problems and difficulties that you have encountered.

Do you think the work of your group has prevented some child abuse or stopped people from doing the sort of thing you hope you can prevent?

BEVERLY. I can't say that for sure, but I know when they come, you know, they are more open and they feel more comfortable and they try to form a better relationship with their kids. If you can identify with someone who is having the same type problem as yourself, then you can sort of work out your problems with your kids when you get home. I know that I have very much so. I have formed a better relationship with my kids. That is not to say that all of my problems are solved. My kids still drive me up the wall sometimes, but I am able to cope with it better.

Senator **CRANSTON.** Do you think that we can find ways to prevent abuse, at least to cut back on it drastically?

BEVERLY. Well, I think we can cut back quite a bit, but I don't know that we can find ways to stop it. I think it is going to always exist.

Senator **CRANSTON.** Once it happens, what do you think should be done?

BEVERLY. Once it happens, I think the parents and the child should have some type of counseling. I don't think that all children should be removed from the home, but, like in my case, I felt that it was necessary to have my son removed from the home, but at the same time the relationship that I did have with my son, the little bit of relationship that I did have, I feel that that has been destroyed since he has been in the foster home.

Do you know how it feels when your son comes up to you and has been, you know, calling you mommie and all of a sudden he is touching you and not calling you anything. Do you know how it feels when you are visiting your son and he says "mommie" and you turn around and he is talking to someone else?

Senator **CRANSTON.** I can imagine.

BEVERLY. You know how it feels when the foster parents say you can come and visit your son at such and such a time and you are not prepared to hear him call someone else mother. Do you know how it feels to have no right to say that his foster parents are not good for your son? If you cared, you would not have abused this child. You know how it feels when people label you without even understanding the reason why this happened, how they point their finger at you? It is a terrible feeling, a terrible ordeal, and you have to have gone through this to understand what I am saying.

Senator **CRANSTON.** I thank you for trying to help us understand because we need to if we are going to try to find ways to be of help.

You have been wonderful to come and I thank you very much. We will try to help, and I hope we can work together. Thank you very much.

We are now going to finally hear from a panel with Ms. Donna Pressma, director, protective services, Department of Children and Youth Services, Hartford, Conn.; Ms. Barbara Sabol, director, Services to Children and Youth, Topeka, Kans., and Dr. Anthony Shaw, chairman, Governor's Commission on Child Abuse and Neglect, Charlottesville, Va.

I would like to ask, if I may, that you try to summarize very briefly your prepared statements. The prepared statements will go in the record in full. That will give us time for a bit of discussion back and forth and some questions, and will enable us to meet some other time problems we face as the day goes on.

I thank each of you very much for your presence here. If you would introduce yourself for the record, I would appreciate it.

STATEMENT OF DONNA PRESSMA, A.C.S.W., DIRECTOR, PROTECTIVE SERVICES, DEPARTMENT OF CHILDREN AND YOUTH SERVICES, HARTFORD, CONN., BARBARA SABOL, DIRECTOR, SERVICES TO CHILDREN AND YOUTH, TOPEKA, KANS.; AND ANTHONY SHAW, M.D., CHAIRMAN, GOVERNORS COMMISSION ON CHILD ABUSE AND NEGLECT, CHARLOTTESVILLE, VA., A PANEL

Ms. PRESSMA. I am Donna Pressma, director of Protective and Children's Services, which is all of the child welfare services in the State of Connecticut. However, I want to note that I am testifying based upon my own opinion and not the opinion of the State of Connecticut.

I also want to note that the recommendations that I have brought with me today are revised from what I had submitted in the written testimony, so I hope you have a revised copy.

You have heard Richard Gelles today testify on the estimated incidence of violence in the American family, leaving between 1.5 and 1.9 million children at risk or in need of some helping services. This widespread problem strongly justifies continuing the leadership role the Federal Government has shown since 1974 in trying to deal with child abuse and neglect.

Public Law 93-247, by establishing the National Center, has greatly enabled states to strengthen their priorities in behalf of abused and neglected children. In order to continue the important prevention and treatment mandates of Public Law 93-247, I have two overall recommendations, one regarding the appropriation and one on the duration of this act.

My own very strong feeling, is that it is not too much to ask that $25 per child be spent for those 1.5 to 1.9 million children. This requires at least $50 million appropriated for next year, or at least appropriate this year the full $25 million originally authorized in 1974.

My second point is to extend the act for 3 more years. This extension should be paralleled by a thorough evaluation of the act's impact on the future needs in the country.

The United States has become a nation that too easily and frequently offers placement of children away from their natural families as a solution to serious family problems of abuse and neglect. And, though unintentional, once these abused/neglected children are removed from their own parents, they are often left too long in temporary placement, or they are shuttled around in a damaging and confusing series of placements. Worse yet, they are sometimes abused or neglected in the State's shelters or substitute homes. Have we really "rescued" these children? From what to what I ask.

Of the 11 specific recommendations contained in my written testimony, I wish to note only 9 at this time. These recommendations are focused on needed Federal programing that would preserve natural families and avoid unnecessary placement of children.

One: Primary prevention must be a well-funded priority. We cannot go on with a wasteful inefficient system that picks up the broken pieces of abuse and neglect without trying to directly impact and decrease its incidence.

Primary prevention should include public school affective education courses being made mandatory beginning in 6th grade. These courses should include basic child development knowledge and experience, education on how to be a parent and education on how to deal with being a single parent.

Prenatal clinics, obstetricians' waiting rooms, hospital maternity wards, Headstart and daycare centers all have captive audiences of parents waiting around for services. These wasted waiting rooms and hospital hours could be filled with training in parenthood skills or child development knowledge and experience.

Two: Crisis intervention services coordinated at a community level needs continued emphasis and Federal support from the Children's Bureau.

Three: More stress on the private sector working in formal coordination with public agencies needs to be encouraged or required in all HEW programs for abused/neglected children. This will expand the number of resources available for combating such a widespread problem.

Four: Most important, the Federal Government should encourage States, via national standards, to offer basic services to abusive or neglecting families based on the utilization of real contracts with the parents and children.

In these contracts the family should be helped to say, what are the goals of treatment, who must do what things to work toward mutually agreed-on positive changes and what progress along the way is or is not occurring. This simple method increases the commitment of the natural family to change and thus increases success with rehabilitating natural families. It also puts back the missing dignity and respect for families that current child welfare services too frequently neglect by not encouraging the family to help itself solve difficult family problems.

Fifth: Federal programing for child abuse and neglect needs to be much more closely coordinated with Federal foster care and adoption programing. These are usually the same children and families being serviced. States are experiencing and duplicating Federal programing fragmentation due to too many different and uncoordinated sources of funding from various HEW branches. The recent reorganization of HEW placing title XX and title IV-B programs under OHD could reduce fragmentation and allow a greater continuity of children's services.

Sixth: Sixty percent of the $50 million I suggested for 1978 funding should go directly to the States as State grants specifically to effect redesign of archaic State protective services systems. This money needs to be used to encourage States to include primary prevention, developing resources to keep natural families together, when possible, upgrading placement of children's services, early identification of high risk families and developing pleasurable sensory treatment plans. Federal child abuse grant money given to States should be allowed to be spent on new types of innovative direct services. However, there should be a phasing-out of such federally supported direct services over a period of several years wherein the State gradually picks up the cost of these ongoing innovative direct services. Also, guarantees from States must be secured so that no State cuts back its current level of funding effort during the years it receives additional temporary Federal funds to enable change to new effective programs.

Seven: Expand the membership of the National Center for Abuse and Neglect Advisory Board required by Public Law 93–247. This Board should help set a limited number of well thought out goals for the National Center for Abuse/Neglect. It should also help evaluate the Center's yearly progress toward these goals. Public and private State persons should be appointed to this Board, in addition to other HEW department representatives. State input would be very effective in suggesting realistic goals for the National Center in areas that really speak to the problems of delivering protective services to the masses.

Eight: Technical assistance from the National Center staff and contractors should be much more intensive on fewer priorities. Technical assistance should help States to reevaluate and redesign grass roots up their current delivery of protective services. This must start with rethinking of the basic purposes behind the State system. Models, like legal, central registry, delivery systems, training packages, are useful to look at and to learn from, but should not be used to superimpose prepackaged best ideas of contractor or National Center that the States then are expected to implement. Some of the models produced for the National Center these past 2 years are laboriously over technical for most States.

Nine: New research and demonstrations funded for 1978 should be even more selective based on the merits of the usefulness of the research hypothesis, rather than on distributing money geographically. Some of the very effective and innovative current research and demonstration centers should be refunded and allowed to function 2 more years. Adequate evaluation of the effectiveness of all research should be planned before any demonstration projects close down.

In closing I want to stress that there be close collaboration between the National Center for Abuse and Neglect and State social service agencies and/or departments for the purpose of planning more effective responses to the problems of abuse and neglect.

Thank you.

Senator Cranston. Thank you very much.

[The prepared statement of Ms. Pressma follows:]

TESTIMONY

on the

NATIONAL CHILD ABUSE PREVENTION AND TREATMENT ACT
PUBLIC LAW 93-247

From:

Donna Pressma, A.C.S.W.

Director of Protective and Children's Services

State of Connecticut

345 Main Street

Hartford, Connecticut 06115

In behalf of:

my own opinions
and not the opinions of the State of Connecticut

Before:

SENATE SUBCOMMITTEE ON HUMAN RESOURCES
Suite 4230
Dirksen Senate Office Building
Committee on Human Resources
Washington, D.C. 20510

April 6, 1977

Testimony for United States Senate on P.L. 93-247

You have (or will have) heard Richard Gelles today testify on the estimated incidence of violence in American families leaving between 1.5 to 1.9 million children at risk or in need of some helping services. This widespread problem strongly justifies continuing the leadership the federal government has shown since 1974 in trying to deal with child abuse and negelct. P.L. 93-247, by establishing the National Center for Child Abuse and Neglect, has greatly enabled many states to strengthen their priorities in behalf of abused and neglected children and their families. Therefore, to continue P.L. 93-247's important prevention and treatment mandates, I urge the Senate:

> to at least* appropriate this year the full 25 million dollars originally authorized in 1974 for P.L. 93-247's third year of implementation and to extend P.L. 93-247 for three more years. This extension should be followed by a thorough evaluation of the Act's impact and of future needs in our country.

The United States has become a nation that too easily and frequently offers placement of children away from their natural families as a solution to serious family problems of abuse and neglect. And, though unintentional, once these abused/neglected children are removed from their own parents, they are often left too long in temporary placement. Or they are shuttled around in a damaging and confusing series of placements. Worse yet, they are sometimes abused or neglected in the state's shelters or substitute homes. Have we really 'rescued' these children? From what? To what?

The following recommendations are focused on needed federal programming that would preserve natural families and avoid unnecessary placement of children.
As a result of fundamental evaluation of youth delinquency, children's mental health and child welfare services in Connecticut, our State has begun to implement what we believe to be a more coherent delivery system of services to these children and their families. As part of this major redesign, I have been an administrator of child welfare services to 30,000 children and parents last year alone. Based on my experiences in Connecticut's state government, I want to add the following recommendations on P.L. 93-247:

1. Primary Prevention must be a well-funded priority.
   We cannot go on with a wasteful inefficient system that picks up the broken pieces of abuse and neglect without trying to directly impact and decrease its incidence.
   a. Primary prevention should include public school affective education courses being made mandatory beginning in 6th grade. They should include basic child development knowledge and experience, education on how to be a parent and education on how to deal with being a single parent.
   b. Prenatal clinics, obstetricians' waiting rooms, hospital maternity wards, Headstart and daycare centers - all have captive audiences of parents waiting around for services. These wasted waiting room and hospital hours could be filled with training in parenthood skills or child development knowledge and experience.

*My own strong feeling is that it is not too much to ask that $25. per child be spent for 1.5 to 1.9 million children. This requires at least 50 million dollars appropriated for next year.

2. Crisis intervention services coordinated at a community level needs continued emphasis and federal support from the Children's Bureau. Facilitating the community to develop coherent responses to families in crisis is significantly more successful, less costly and less time-consuming than trying to rehabilitate long-standing family breakdowns. Nashville, Tennessee's Comprehensive Emergency Services model has been important for states to learn about and to try to implement.

3. More stress on the private sector working in formal coordination with public agencies needs to be encouraged or required in all H.E.W. programs for abused/neglected children. This will expand the number of resources available for combating such a widespread problem. The extent of the widespread problems of abuse and neglect require this cooperation if any chance of delivering minimal quality services are to be achieved.

4. Most important, the federal government should encourage states (via national standards) to offer basic services to abusive or neglecting families based on the utilization of real contracts with the parents and children.
   In these contracts, the family should be helped to say:
   a. what the goals of treatment will be;
   b. who must do what things to work towards mutually agreed-on positive changes; and
   c. what progress along the way is or is not occurring. The family should help to evaluate whether one contract party member is or is not living up to his/her contracted promise. This simple method increases the commitment of the natural family to change and thus increases success with rehabilitating natural families. It also puts back the missing dignity and respect for families that current child welfare services too frequently neglect by not encouraging the family to help itself solve difficult family problems.

5. Federal programming for child abuse and neglect needs to be much more closely coordinated with federal foster care and adoption programming. These are usually the same children and families being serviced. States are experiencing and duplicating federal programming fragmentation due to too many different and uncoordinated sources of funding from various H.E.W. branches. The recent reorganization of H.E.W. placing Title XX and Title IV B programs under O.H.D. could reduce fragmentation and allow a greater continuity of children's services.

6. 60% of the 50 million I suggested for 1978 funding should go directly to the states as state grants specifically to effect redesign of archaic state protective services systems. This money should be used to encourage states to include primary prevention; keeping natural families together whenever possible; upgrading 'placement of children' services and early identification of high risk families. Federal child abuse grant money given to states should be

allowed to be spent on new types of innovative direct services. However, there should be a phasing-out of such federally-supported direct services over a period of several years wherein the state gradually picks up the cost of these on-going innovative direct services. Also, guarantees from states must be secured so that no state cuts back its current level of funding effort during the years it receives additional temporary federal funds to enable change to new effective programs.

7. Expand the membership of the National Center for Abuse and Neglect Advisory Board - required by P.L. 93-247.
   This expanded Board should help to set a limited number of well thought-out goals for the National Center for Abuse/Neglect. It should also help to evaluate the Center's yearly progress towards these goals. Public and private state persons should be appointed to this Board (in addition to other H.E.W. department representatives). State input would be very effective in suggesting realistic goals for the National Center in areas that really speak to the problems of delivering protective services to the masses.

8. Technical assistance from the National Center staff and contractors should be much more intensive on fewer priorities.
   Technical assistance should help states to re-evaluate and redesign grass roots up their current delivery of protective services. This must start with re-thinking the basic purposes behind the state system. Models (legal, central registry, delivery systems, training packages) are useful to look at and to learn from but should not be used to superimpose pre-packages "best ideas of contractor or National Center" that the states then are expected to implement. Some of the models produced for the National Center these past two years are laboriously over-technical for most states.

9. The National Center for Abuse/Neglect staff should spend time coordinating and advocating joint primary prevention and crisis intervention programs with the Office of Education, H.E.W., with the National Hospital Association, with the Office of Health, H.E.W., with the National Homemakers Association and with H.E.W. Daycare specialists.

10. New research and demonstrations funded for 1978 should be even more selective based on the merits of the usefulness of the research hypothesis rather than on distributing money geographically.
    Some of the very effective and innovative current research and demonstration centers should be refunded and allowed to function two more years. Adequate evaluation of the effectiveness of all research should be planned before any demonstration projects close down.

11. The National Center for Abuse/Neglect should continue its high priority on enabling states to quality-train protective service workers, supervisors and other professionals who help to service abused/neglected children and their families.

In closing, I want to stress that there be close collaboration between the National Center for Abuse and Neglect and state social service agencies and/or departments for the purposes of planning more effective responses to the problems of abuse and neglect.

Senator CRANSTON. Next we will hear from Barbara Sabol.

Ms. SABOL. I am Barbara Sabol, director, Services to Children and Youth, Topeka, Kans. The division incorporates all children's services, including protective services.

There was previous testimony about the State of New York and the incidence of child abuse and neglect there and somehow when you talk about New York City you kind of say, aha, that is New York City, but I am from Kansas and Kansas is usually described as a rural State, so for the purpose of giving you some idea about the magnitude of the problem in what is described as a rural state, let me give you a few statistics.

Since the revision of our Child Abuse Reporting Act of 1972 we have had a total of 23,045 reports of suspected child abuse and neglect. To date in this fiscal year, and there are 3 months left to go, we have had 6,243 reports. This is more than all of the reports in the last fiscal year.

In the State of Kansas in fiscal year 1976 we were able to identify 17 children who died as a result of abusive behavior. In the State of Kansas there were 226 cases of suspected sexual abuse reported. Ninety of these were confirmed. Of the perpetrators of child abuse, suspected child abuse and neglect, 88 percent of the alleged perpetrators are parents.

Now one of the things that I would like to stress very strongly is that ultimately it is the State who has responsibility for the prevention, identification and treatment of child abuse and neglect. The clients, the families, the children, are there and we need to be able to respond. If we are to keep families together and if we are to reunite them when they must be temporarily separated, this requires a trained, adequate staff resources to meet the need. One of the things that I think we need to give attention to is the development of sound and manageable ways of recruiting and retaining child protective service workers. This is a highly stressful job and perhaps this even merits some research and attention.

In Kansas our approach to child abuse and neglect is that it is a community problem and that the community has to be involved in the solution of this problem. I won't speak to some of the specific things we are doing in Kansas because that is in the written testimony, but I would like to make some comments about the emphasis that has been placed in the national act on research. It appears to us at the State level that there are more research findings and knowledge available than we are currently able to implement and it seems to us that it is now time to do what we know and to do what we know takes resources.

Public awareness campaigns, training mandatory reporters how to report, early identification and even development and utilization of predictive tools will have little impact on the problem of child abuse and neglect if there are not appropriate services available and people to deliver those services. There must be additional funding at the State level to address the State's needs and priorities.

You may ask if you had the additional funding, what would you do? We must strengthen our in-home services. We must utilize the knowledge we have about home visitors and its impact on the prevention of child abuse and neglect. We must enlarge the parent aide programs.

In Kansas we have 150 counties and in only 2 counties do we have a parent aide program. We must facilitate the development of additional emergency resources and development of crisis day care. We must have a way of implementing more managable protective service case loads and increase our ability to provide training and education for parents to help them become more competent in the parenting role.

In terms of specific recommendations, any language in the current act that is a barrier for the participation of States must be removed. I think States are moving toward meeting the intent of the legislation, but no State should be prohibited from participation and that language should be changed from "shall" to "should."

I would further recommend that 75 percent of the funds appropriated under this act be granted to the States so that the States who ultimately have a responsibility for the delivery of services can develop programs and priorities around their own needs.

I further recommend that if the State's share is increased to 75 percent of the funds appropriated under this act that there should be a State plan for expenditure of those funds and that that State plan should be subject to public review and public comment. This is a community problem and we must use every vehicle to assure that the community can participate and impact on what is happening as it relates to the prevention and treatment of child abuse and neglect. The public review and comment process will also provide us an opportunity to dispel some of the myths about child abuse and neglect, for example, that it only affects minorities and the poor.

I would further recommend that there be established an advisory committee to the National Center on Child Abuse and Neglect and that the membership of this advisory committee include representatives of minority groups and the public sector. I would see this advisory committee advising and assisting in the coordination of programs and advising and assisting in the development of national standards and setting goals and objectives.

I would recommend the continued support of the resource centers and, additionally, after giving it considerable thought, I would recommend that the reauthorization of Public Law 93-247 for 3 years only if the State's share of participation in the act is substantially increased and only if all States will have the opportunity to also participate.

If these conditions cannot be met, then I would recommend that a reauthorization for 1 year and during that time a refinement of the goals and objectives and a clear delineation of the Federal responsibility.

I would like to give special note, and it deserves special attention and the testimony of Beverly supports this, that the Parents Anonymous program deserves special note by the committee. In Kansas the Parents Anonymous chapters are increasing and as a public welfare agency we find this an available resource in providing services to abusing parents.

I am also a member of the Education Commission of the States' National Advisory Committee on Child Abuse and Neglect. This committee has looked very carefully at this act and has made a set of recommendations and those recommendations are in my written testimony and are somewhat correlated with the testimony I have previously given, so I won't speak specifically to them, but they are in the written copies.

Thank you for this opportunity.

Senator CRANSTON. Thank you very much.

[The prepared statement of Ms. Sabol follows:]

STATE OF KANSAS
ROBERT F. BENNETT, Governor

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
State Office Building
TOPEKA, KANSAS 66612
ROBERT C. HARDER, Secretary

Division of
Vocational Rehabilitation

Division of
Social Services

Division of
Mental Health
and Retardation

Division of
Children and Youth

Division of
Administrative Services

Alcohol and Drug Abuse
Section

State Office
Economic Opportunity

STATEMENT FOR

HEARINGS ON CHILD ABUSE PREVENTION & TREATMENT ACT

SENATE SUBCOMMITTEE ON CHILD & HUMAN DEVELOPMENT

April 6, 1977

By:

Ms. Barbara J. Sabol, Director
Division of Services to Children & Youth
Kansas Department of Social and Rehabilitation Services

TESTIMONY OF
BARBARA J. SABOL
BEFORE
THE SENATE SUBCOMMITTEE ON CHILD & HUMAN DEVELOPMENT

April 6, 1977

The Honorable Robert F. Bennett, Governor of Kansas, and Chairman of the Education Commission of the States' Advisory Council on Child Abuse and Neglect, wrote in an article published in Compact that:

> "...State policy makers must, however, act and take the initiative and seek appropriate information and research findings to make policy which will bring about the proper climate to provide the best available services to families in peril. It is not permissible to allow families to unduly suffer and children to be abused and/or neglected while our society battles the semantics of the problem. Recognizing the family and the child's need for protection is obviously more important than determining the form of maltreatment involved.
>
> "...There has been much discussion in the last several years regarding multidisciplinary efforts and activities that should occur in child abuse and neglect management. Having been a former state senator for a number of years and a governor, I know that it is difficult to mandate or legislate the three C's--communication, coordination and cooperation. This seems to be one of the largest obstacles in the overall delivery system of services to families in stress and children in peril Basically, different professions that must, of necessity, communicate, cooperate and coordinate to provide services to abused and neglected children and their families often do not understand and/or trust one another. State policy makers in their deliberations must consider child abuse and neglect as a multidisciplinary, multiagency issue."

This statement reflects the policy and commitment of Kansas to address the problems of families in peril via for a multidisciplinary, coordinated approach.

The following information about Kansas will provide background that indicates the reported magnitude of the problem of child abuse and neglect in Kansas. There are 2,310,000 citizens in Kansas--808,500 of whom are children 0 to 18 years of age, representing 35 percent of the total population. Of the child population in Kansas, 33.9 percent (274,082) live in rural Kansas and 66.1 percent (534,418) live in urban areas.

The Kansas Child Abuse and Neglect Reporting Act was passed by the 1965 Legislature and revised by the 1972 Legislature to provide for reporting of suspected abuse/neglect to the Kansas Department of Social and Rehabilitation Services. Since the passage of that act, 23,045 reports of suspected child abuse and neglect have been reported to the Kansas Department of Social and Rehabilitation Services. The following graph indicates the number of reports received by fiscal year. There was a 25.1 percent increase in reporting from Fiscal Year 1974 to Fiscal Year 1975. To date this Fiscal Year, we have had more suspected child abuse/neglect reported (6,243 reports) than in all of Fiscal Year 1976 (6,113 reports).

REPORTS OF ABUSE/NEGLECT RECEIVED

	Abuse	Neglect	Total
Fiscal Year 1973	1,010	1,152	2,162
Fiscal Year 1974	1,152	2,634	3,786
Fiscal Year 1975	2,212	2,529	4,741
Fiscal Year 1976	2,054	4,059	6,113
Fiscal Year 1977 (to date 3/31/77)	2,222	4,021	6,243

With that brief overview of the status of reporting in Kansas let me turn to the issue of Federal-State responsibility in the area of child abuse and neglect.

Responsibility

It is the State which has the direct responsibility of prevention, identification and treatment of child abuse and neglect. It is the State that is ultimately responsible for assuring a response to individuals and families in need of service. In Kansas, state employed service workers must meet mandates which specify prompt investigation (a contact with the family within 24 hours based on immediacy of need; in no case later than 72 hours); developing appropriate service plan and providing services. With the increasing number of reports, the "on call" nature of the assignment, there is concern about burnout of local workers. Frustration on the state and local level increases as we find ourselves without as many resources as are needed and at the same time we see more federal dollars being spent on collection of statistics and on the awarding of contracts of questionable size with questionable goals with the expectation of minimal results on behalf of children and their families.

Dr. Vincent DeFrancis states that abuse programs could be assessed on the following criteria:

1) To respond promptly;
2) To explore all reports;
3) To assess the damage of children in all reported instances;
4) To evaluate the risk to children from continued exposure to neglect;
5) To offer necessary remedial casework services;
6) To take summary action where warranted through involving the authority of the juvenile court or family court.

There is ample evidence to support the need for specialized skills of child protective service workers. If we are to keep families together and reunite them when they must be temporarily separated, then attention must be given to developing sound and manageable ways of recruiting and retaining protective service workers. Perhaps this is an issue that merits attention by researchers.

Title XX funds are being utilized toward the prevention and treatment of child abuse and neglect, however, Kansas is now bumping against its ceiling. In fiscal year 1977, the Title XX estimated expenditures indicated 10.8 percent for protective services. In the fiscal year 1978 proposed plan which was published April 1, the estimated expenditures for protective services represented 53.8 percent of the total expenditures. Working with the realities of the Title XX ceiling, less than $50,000 per year from P.L. 93-247, increased reporting, increased pressure on resources, i.e. day care, emergency shelter, we continue to identify ways to coordinate services and stretch ourselves to meet the increased demands.

In Kansas the State Department of Social and Rehabilitation Services has the responsibility for receiving and investigating reports and for providing services. However, we recognize that these are not responsibilities we can carry out in isolation. We operate from the premise that child abuse and neglect is a community problem, thus the community must be involved in the development of solutions directed at prevention and treatment.

The Kansas Unit of the National Committee for the Prevention of Child Abuse under the leadership of a superb volunteer, Ms. SuEllen Fried, has been working in Kansas since February 1976. Largely through the efforts of this group and the Advisory Committee to the Division of Services to Children and Youth, there has been a Governor's Conference on the Prevention of Child Abuse/Neglect, a Governor's Seminar on Education for Parenthood (a primary prevention strategy), and a tremendous amount of energy and enthusiasm throughout the state--rural and urban--directed at developing solutions best suited to the local need.

All state agencies who impact on children (Department of Social and Rehabilitation Services, Department of Health and Environment, Department of Education, Governor's Committee on Criminal Administration, Department of Human Resources, Board of Regents, Court system) and the volunteer sector represented by the Kansas Unit of the National Committee for the Prevention of Child Abuse are meeting on a monthly basis (with take home assignments in the interim) to develop a "real" state plan directed at the prevention and treatment of child abuse and neglect. The state plan will specify the goals and objectives and what each agencies' responsibility is toward meeting those goals with timetables and a system for monitoring achievement. As the plan is developing, the membership go back to their respective agencies and begin working on specific ideas and tasks so that some tasks specified in the plan will be completed long before the plan itself. This cooperative, coordinated effort is designed to decrease the probability of duplication and to state clearly the state policy and plan regarding child abuse and neglect. This exemplifies the kind of coordination that we are working so hard on at home. The problems associated with child abuse and neglect are too many and too complex to allow duplication of effort and there must be a mechanism established to assure that there is not duplication of effort at the national level.

Research

There appears to be more findings and knowledge regarding child abuse and neglect currently available than is being used. There comes a point when you must do what you know. For "research" to be meaningful at the front line, it must be published in language that can be assimilated by administrators and translated into an implementation plan that fits our own unique needs. Research findings must have some applicability to the problems that confront us on a daily basis and then there must be support for implementing the findings. I have concern that much of the literature is directed at abuse and there needs to be increased attention given to the problem of child neglect. Our reporting indicates that there are twice as many reports of neglect as abuse.

Programs and Service Delivery

Public awareness campaigns, training mandatory reporters how to report, early identification, and even the predictive tools will have little impact if there are not appropriate services available. Additional funding to the state to address the state's needs and priorities is one step. What would we do if we had additional funds?

1) Develop at least one additional "home visitor" program.
2) Strengthen the in-home services component of the preventive/protective service program with the goal of decreasing the number of children who must be removed from their home.
3) Enlarge the parent aide program currently operating in two of the 105 counties.
4) Facilitate the development of additional emergency services (day care and 24 hour care).
5) Implementation of more manageable protective service caseloads.
6) Increase our ability to provide or purchase training and education for parents to help them become more competent in the parenting role.

Delivery of services that assist families to remain intact or reunite them as soon as possible is the bottom line of treatment, however, any of the above activities is appropriate as preventive strategies for identified high-risk families.

Recommendations

1) Remove barriers that prevent states from participating by changing the language in Section 4(b)(2) of the Act to read: "In order for a state to qualify for assistance under this subsection, such state should..."

Discussion: The Act itself states that funds may be used by the Secretary for making grants to the States for "...the purpose of assisting states in developing, strengthening and carrying out child abuse and neglect programs." Any barriers that prohibit states from participating can be deleterious to the very client we want to assist. Building the capacity of the state to address the problem should be the goal and no state should be excluded from participation in this grant program.

2) Increase the amount of funds going to the state and assure that these funds will go to the states for strengthening and carrying out child abuse and neglect treatment programs by changing the language in Section 4(b)(1) to read, "Of the sums appropriated under this Act for any fiscal year, not less than 75 percent shall be used by the Secretary..."

Discussion: I mentioned earlier the problem of burnout, turnover, increased number of cases reported and the increased pressure on current resources. Additional funds at the state level can assist in addressing these problems by providing states the opportunity to address their priorities and needs and build the capacity to respond to the increased reporting and for the expansion of preventive services. There are research results that are ready for implementation that have the potential for positive impact on this problem. This Act can provide the basis for such implementation.

3) Should the state share be increased to 75 percent, the state plan for expenditure of these funds may warrant public review and comment. How a state chooses to implement any public review and comment should be left to the individual state.

Discussion: Child abuse and neglect is a community problem. Although there are costs associated with the process of public review and comment, it increases the probability that agencies are not trapped into building kingdoms but responding to real needs. Public review provides opportunities for communities to speak directly to the priorities and directions of preventive and protective services. This is necessary if we are to effect a coordinated approach to child abuse and neglect.

4) Establish an Advisory Committee to the National Center on Child Abuse and Neglect whose membership will include representation from minority groups and the public sector.

5) Continued support of the Resource Centers.

Discussion: The Resource Centers have provided an excellent vehicle for communication between the states and training of key people. Materials developed by the Resource Centers have been shared with Junior League and students in a School of Nursing and with volunteer organizations.

6) Reauthorization of P.L. 93-247 for three (3) years if there is a significant increase in state participation.

Discussion: Recent experiences with P.L. 94-401 indicate the difficulties of getting plans effected and systems in operation with the constraint of one year funding, i.e. the employment of AFDC recipients in day care facilities. Just as this program will get in full swing--people employed, trained, knowledgeable, comfortable with their jobs--then its back to go unless additional funds are forthcoming. I spoke previously to the significant increase in the estimated expenditures in the proposed fiscal year 1978 Title XX plan directed to protect individuals from abuse, neglect and exploitation and to help families stay together. The additional resources to the state provide opportunities for demonstration and development capacity which is not possible under Title XX.

The Parents Anonymous program merits special note. Parents Anonymous Chapters in Kansas are increasing. This program is becoming a valuable resource for abusing parents and we urge its continued support.

The Education Commission of the States' National Advisory Committee on Child Abuse and Neglect has recommended amendments to P.L. 93-247 (see attachment). The purpose of this committee is to offer alternatives to state educational and legislative leaders on how their respective systems may enhance the national campaign to eradicate child abuse and neglect. The amendments as proposed by this committee are designed to strengthen the campaign toward eradicating child abuse and neglect in this country.

Senator **Cranston**. The next witness will be Dr. Shaw from the University of Virginia.

Dr. **Shaw**. Senator Cranston, my name is Anthony Shaw and I am a professor of surgery and chief of pediatric surgery at the University of Virginia. I am also chairman of Virginia's State Advisory Committee on Child Abuse and Neglect and one of the authors of the Child Abuse Law passed by the Virginia General Assembly in 1975.

Representing Virginia here today, I would like to express the Commonwealth's appreciation for the National Child Abuse Prevention and Treatment Act in several respects.

First: Passage of the act itself, with its promise of Federal funds, gave us some very important leverage with the Virginia General Assembly in gaining passage of comprehensive child protection legislation in the 1975 session. This made us one of the first States to qualify for assistance under the National 'Act.

Second: With the help of the grant to our department of welfare and with the assistance given the department by the National Center for Child Abuse and Neglect, Virginia moved quickly to establish a comprehensive and coordinated system of protective services. William Lukhard, our commissioner of welfare, has, in his written report to this subcommittee, enumerated the ways in which Virginia has benefitted from the support given under this act, and I will not repeat all of this material.

Third: The National Act has supported a protective services demonstration project in Northern Virginia—Pro Child. We just heard something about Pro Child because it is a program the first mother credited with helping her so much. This was developed under the auspices of Arlington's Department of Welfare. Through its multifaceted detection, treatment, and prevention programs, Pro Child has served this large community well with increasing caseloads, reduced costs per case, and services to families which have resulted in great reduction of numbers of children placed in foster care, and reduced time in foster care, for those temporarily placed.

As a surgeon, I am generally impatient with approaches to disease that cannot produce immediate results and quick cures. But I know that many of our cherished notions about diagnosis and treatment of disease are not always based on sound scientifically proven data and that truth in medicine is derived from the slow process of experimentation, controlled studies, observations by trained scientists over long periods of time with constant testing of techniques and of hypotheses.

Just because we don't fully understand the cause of, and don't know how to prevent a disease, should not mean that we should not use what knowledge we have to try to treat and even cure it while we are at the same time working toward a better understanding of it. Such efforts require a long term and continuing sense of direction and that means to me that the National Center for Child Abuse and Neglect must be assured of existence for at least another 3 to 5 years, with the necessary staff to do the continuing job of acting as a national resource center, funding and supervising programs and directing research. We have had all too much experience with projects such as the regional medical programs where uncertainty about continued funding from year to year make it absolutely impossible for those of us who wished to embark on programs requiring more than a 6-month commitment of personnel and money to do so.

Virginia has used its limited resources very effectively in developing its statewide system of protective services. Its current budget is about $260,000, about half of which derives from the Federal grants through the act and the other is appropriated from the State. Moneys provided through the National Act to regional agencies such as Development Associates, Washington School of Psychiatry, and Howard University, have been crucial to our early efforts in that these agencies, with varying degrees of success, have helped us in all facets of training, education, and publicity programs at State, regional, and local levels, as well as in the development of the State hot line, central registry, and various community resources such as multidiscipline teams, of which we now have 60 in the State. We continue to need help in the development of increasingly sophisticated and comprehensive programs. However, we feel that at the present time our own agencies have developed the expertise to allow us to make our own decisions about the kinds of help we would like to continue to receive.

If we had direct access to the money which is now going to third party contracting agencies, we would, with the help of NCCAN and other resource centers, be able to pick and choose the consultants and experts from within our State and from elsewhere in the country to help us with our developing programs and to address our needs as we foresee them.

The imminent demise of Pro Child raises another problem. The 3 years are up. Many States and communities are unable to immediately assume all the continuing costs of a project initially heavily funded by the Federal Government, even if some elements can be subsidized under title XX. If funding for Pro Child were to be gradually phased out at the Federal level instead of simply cut at the end of its 3-year run, it would make it easier for the community and the State to assume the financial responsibility for the elements of the program which they wish to maintain.

Virginia has seen the great increase in numbers of suspected victims of abuse and neglect. There were over 21,000 in the first year of its new State law. We have made a commitment to help these children and families. As the numbers reported rise, many of our agencies are falling further behind, are having trouble keeping up with investigations, let alone service demands on their time.

I believe so strongly in the need for good research that I would hate to suggest reduction of the research component of the act should it be renewed at current funding levels. However, children and families in need can't wait until we have all the answers. We have to keep working with the knowledge we have, imperfect as it may be, and I therefore urge you to renew the act with a strong research component, but with greatly increased allowances for State agencies to allot according to their own perception of their needs in dealing with abuse and neglect. I agree that as a condition of receiving the moneys, States should meet certain minimal legislative, administrative, and structural criteria, which should be under periodic review.

If I can summarize five recommendations that are in the testimony somewhere. One: That Public Law 93–247 should be extended for 5 years. Two: That the National Center for Child Abuse and Neglect should be continued for the life of the act, with adequate staffing to fulfill its roles in providing informational and other materials and training and technical assistance and research. Three: That funding for State service programs should be greatly expanded under the act, preferably without curtailing the research component. Additional funding under the act should go into services, rather than research. Four: That States should be allowed the discretion and money to contract for educational and training programs of their own choosing and developing research centers of their own, rather than required to deal with regional, private, or public agencies under contract to HEW. Five: That Federal funded demonstration programs which show promise or have proved of value should not be abruptly terminated at 3 years, but should continue to be supported at diminished levels in order to give States and communities an opportunity to gradually assume financial responsibility for the program, or those elements of the program that we should maintain.

Thank you very much.

[The prepared statement of Dr. Shaw follows:]

April 4, 1977

Testimony to the Senate Sub-committee on Child and Human Development with Respect to Renewal of the Child Abuse Prevention and Treatment Act.

Gentlemen: My name is Anthony Shaw. I am a Professor of Surgery and Chief of Pediatric Surgery at the University of Virginia. I am also Chairman of Virginia's State Advisory Committee on Child Abuse and Neglect and one of the authors of the Child Abuse Law passed by the Virginia General Assembly in 1975.

Representing Virginia here today, I would like to express the Commonwealth's appreciation for the National Child Abuse Prevention and Treatment Act in several respects.

First: Passage of the Act itself, with its promise of federal funds, gave us some very important leverage with the Virginia General Assembly in gaining passage of comprehensive child protection legislation in the 1975 session. This made us one of the first states to qualify for assistance under the National Act.

Second: With the help of the grant to our Department of Welfare and with the assistance given the department by the National Center for Child Abuse and Neglect, Virginia moved quickly to establish a comprehensive and coordinated system of Protective Services. William Lukhard, our Commissioner of Welfare, has, in his written report to this sub-committee, enumerated the ways in which Virginia has benefitted from the support given under this Act and I will not repeat all this material. I would like to point out one feature of the Virginia Law which has been helpful in the development of protective services in the Commonwealth. The 1975 Virginia Child Abuse Act, of which I was an author, created a committee advisory to the Governor, the Board of Welfare and the Commissioner of Welfare on child abuse and neglect matters. This Advisory Committee, which I have the privilege of Chairing, consists of the heads of the major state agencies, as well as a citizens group, the latter appointed by the Governor for three year staggered terms. This committee has worked closely with the State Bureau of Child Abuse and Neglect since its inception and through it's sub-committee structure has been the vehicle for allowing broad citizen participation in the development of policy and programs in the child abuse area and has allowed us to help in the coordination of these efforts at state, regional and local levels. Monies from the federal grant have helped pay for meeting connected expenses of Advisory Committee members and for some of our clerical costs. Sub-committees of the Advisory Committee, with memberships derived from communities throughout the Commonwealth, address themselves to studying and making recommendations on needs assessment, legislation, volunteers, public awareness, prevention and treatment, and multi-discipline teams. The multi-discipline team sub-committee has served as the cooperating agency within the state to work with the HEW-funded contractor, Development Associates, Inc., which is charged with helping develop model multi-discipline teams in region III. (Even before the relationship with Development Associates was developed, some 60 community and hospital based multi-discipline teams were operating in Virginia, providing a receptive soil for seed money and demonstration projects at regional and local levels.)

Third: The National Act has supported a protective services demonstration project in Northern Virginia - Pro Child - developed under the auspices of Arlington's Department of Welfare. Through its multi-faceted detection, treatment and prevention programs, Pro Child has served this large community well with increasing case loads, reduced costs per case, and services to families which have resulted in great reduction of numbers of children placed in foster care and reduced time in foster care for those temporarily placed.

As a surgeon, I am generally impatient with approaches to disease that cannot produce immediate results and quick cures. But I know that many of our cherished notions about diagnosis and treatment of disease are not always based on sound scientifically proven data and that truth in medicine is derived from the slow process of experimentation, controlled studies, observations by trained scientists over long periods of time with constant testing of techniques and hypotheses.

For these reasons I have no illusions that the etiology of child abuse, which is a far more complex problem than many of the diseases I encounter in my practice, will be solved overnight or by three year demonstration projects. I suspect that in order to arrive at some fundamental truths about the causes and prevention of abuse and neglect, some research programs and demonstration projects will need to be funded over considerably longer periods of time than is now customary and that such efforts will need to be given a continuing sense of direction.

Now just because we don't fully understand the cause of, and don't know how to prevent, a disease should not mean that we should not use what knowledge we have to try to treat and even cure it, while we are at the same time working toward a better understanding of it. Such efforts require a long term and continuing sense of direction and that means to me that the National Center for Child Abuse and Neglect must be assured of existance for at least another three to five years with the necessary staff to do the continuing job of acting as a national resource center, funding and supervising programs and directing research. We have had all too much experience with projects such as the Regional Medical Programs where uncertainty about continued funding from year to year made it absolutely impossible for those of us who wished to embark on programs requiring more than a six month commitment of personnel and money to do so.

Virginia has used its limited resources very effectively in developing its state wide system of protective services. Monies provided through by the National Act agencies such as Development Associates, Washington School of Psychiatry and Howard University, have been crucial to our early efforts in that these agencies, with varying degrees of success, have helped us in all facets of training, education, and publicity programs at state, regional and local levels as well as in the development of the state hot line, central registry and various community resources such as multi-discipline teams. We continue to need help in the development of increasingly sophisticated and comprehensive programs. However, we feel that at the present time, our own agencies have developed the expertise to allow us to make our own decisions about the kinds of help we would like to continue to receive.

We feel, for example, that the training contract through Howard University has been helpful to us in some ways but not in others and that if we had direct access to the money which is now going to third party contracting agencies, we would, with the help of NCCAN and other resource centers, be able to pick and choose the consultants and experts from within our state and from elsewhere in the country to help us with our developing programs and to address our needs. I believe that once a state develops a certain degree of sophistication in child abuse and neglect matters, the law should allow it greater discretion in the management of its continuing programs. We would like to develop our own resource centers and pools of expertise within the Commonwealth and feel we would like to make our own choices as to what groups and agencies can give us the best help with these.

The imminent demise of Pro Child raises another problem. Many states and communities are unable to immediately assume all the continuing costs of a project initially heavily funded by the Federal Government, even if some elements can be subsidized under Title XX. Certainly demonstration projects that do not show promise, or fail to live up to expectations, should be cleanly terminated. However, if a demonstration project is judged successful or promising it should be continued at some level of funding instead of stopping it all at once. If funding for such a program as Pro Child were to be gradually phased out at the Federal level instead of simply cut, it would make it easier for the community and the state to assume the financial responsibility for the elements of the program which they wish to maintain.

Virginia has seen, in common with other states with effective reporting laws and acitve educational and publicity programs, a great increase in the number of suspected victims of abuse and neglect - over 21,000 in the first year our new state law has been in effect. We have made a committment to help these children and their families. Right now as the numbers reported rise, many of our agencies are falling farther behind. Some are having trouble keeping up with investigational, let alone service demands on their time.

I believe so strongly in the need for good research that I would hate to suggest reduction of the research component of the Act should it be renewed at current funding levels. However, children and families in need can't wait until we have all the answers. We have to keep working with the knowledge we have, imperfect as it may be, and I therefore urge you to renew the Act with a strong research component but with greatly increased allowances for state agencies to allot according to their own perception of their needs in dealing with abuse and neglect. I agree that as a condition of receiving the monies states should meet certain minimal legislative, administrative and structural criteria which should be under periodic review.

Finally, we would like to see NCCAN function in a manner of more practical day to day help to our state regional and local agencies. If NCCAN is continued, as it should be, it must have adequate staffing to enable it to do a good job for us. Descriptions and evaluations of demonstration projects and the fruits of other research efforts should be moved along to the directors of state programs quickly and regularly. We should not have to receive most of our vital information about major books, research documents, educational and other training materials, grants, national workshops and new federal programs in the child abuse area from a dozen different sources (the best of which currently happens to be the colorfully written "Child Protection Report"). There should be a direct pipeline between NCCAN and state agencies seeing to it that such agencies are kept current on all moves at the federal level having impact on abuse programs as well as keeping state program directors current on what is being done at the state and community level elsewhere.

Thank you

SUMMARY OF RECOMMENDATIONS

1. P.L. 93-247, the Child Abuse Prevention and Treatment Act should be extended for five years.
2. The National Center for Child Abuse and Neglect should be continued for the life of the Act with adequate staffing to fulfill its roles in providing informational and other materials, in training, in technical assistance and in research.
3. Funding for state service programs should be greatly expanded under the Act preferably without curtailing the research component. Additional funding under the Act should go into services rather than research.
4. States should be allowed the discretion and money to contract for educational and training programs of their own choosing and to develop resource centers of their own rather than be required to deal with regional, private or public agenices under contract to HEW. NCCAN should help put state agencies in touch with the resources they need.
5. Federally funded demonstration projects which show promise or have proved of value should not be abruptly terminated at three years but should continue to be supported at diminishing levels in order to give states and communities an opportunity to gradually assume financial responsibility for the program or for those elements of the program they wish to maintain.

ANTHONY SHAW, M. D.

Senator **Cranston**. Thank you very much for your very helpful testimony.

There are several questions I would like to ask each of you. In some cases some of you have already covered the question. I will try to indicate that.

If I may start with Ms. Pressma and Ms. Sabol. Would you each very briefly outline the process by which your State is certified to be eligible for funding under the State grant program and indicate how long that took and whether you had any problem of meeting the eligibility requirement?

Ms. **Pressma**. That is a loaded question. We are eligible in Connecticut after a long, hard battle. It took almost several years—2 years—before we actually saw the results of the final stamp of approval on our eligibility. There comes a point where the legalese in the law doesn't do a darn thing for the child that is being abused and neglected and not getting the direct services that that money could have been spent for. I think that to some degree working with the States and determining eligibility makes a State pay attention to some important elements that need to be in the statutes to protect children and families. So it is not a black or white issue. But I think it got to the point of the absurd. What is more important is that the State, in its direct delivery of service, really basically does what the intent of the eligibility guidelines were, rather than the phraseology in the law. And my own point of view is that NCCAN belabored the point for those of us who are trying to directly deliver service. This year, again, in order to remain eligible for continued State grants, we have a new packet of smaller subpoints, even for the States that are eligible, that we now have to comply with or attempt to comply with to continue to get Federal money. The amount of hours for a State programer that you must spend on this extreme detail in order to just receive your Federal money takes away time from delivering the direct services. That is Connecticut's experience.

Senator **Cranston**. Ms. Sabol, would you respond?

Ms. **Sabol**. I could almost say ditto. However, I think that Kansas does now comply and it is eligible. However, it was a long, arduous process and many times it appeared to be a nitpicking word semantics argument rather than the specific content and was Kansas or was Kansas not meeting the intent of the law and I think all during this we were meeting the intent.

I would further say the purpose of the act, as I see it, is to have some impact upon the delivery of services to abusing families and the children and when States are not allowed to participate, you are subverting that very goal.

Senator **Cranston**. How do you use the funds in your State?

Ms. **Sabol**. Let me describe our current project. Right now we have funded a private project around the home visitor concept in which we have contracted with the local health department in a community that has an Army installation. It has been identified as a high risk in terms of infant mortality and we are working together, all of the local agencies, the volunteer agencies and the public welfare sector to implement this home visitor program where mothers are identified in the hospital and are then visited right now and it is for 1 year's time at varying lengths of time during the infancy and early childhood stages. We hope that this is a preventive approach. If they demonstrate it does have preventive aspects in other communities and other counties, then we hope to replicate that in Kansas.

Senator CRANSTON. Back to Connecticut. What are the principal uses of funds there?

Ms. PRESSMA. Two. One critical thing we could never do with existing State funds was our emergency coverage system. That begins with a statewide hotline in the private sector—so that there is less negative connotation that the State owns it. This is an emergency line which operates night and day, on holidays and weekends. Then we have developed a system—including certain uses of a central registry—with an ability to respond with workers on standby in every region. They can within minutes of a phone call, be there with a family in crisis. The second use is for developing comprehensive local community coordinated services—public and private—to respond to abusive neglecting families.

Senator CRANSTON. I would like to ask all three of you this question: Do you think the formula for receiving funds should be changed and, if so, how, under the State formula program?

Ms. SABOL. I am not sure I have any specific recommendations with how the formula ought to be changed. The basic 20,000 and based on population is probably as viable as some other things that we could come up with. I think the amount that is currently being allocated to the States needs altering, and again my 75 percent recommendation.

Senator CRANSTON. Do you have any comments on that?

Ms. PRESSMA. My formula is that it stay basically the same proportion, but note I ask for more money—$50 million—for the whole act. I said more needs to come into the States, and I would agree with my friends from Kansas that State grant money definitely is money well spent in delivering better services to the masses. But I do think there are some things possible that the National Center can do with their having other funds that we as an individual State can't do. With such funds they in fact could come into the State and offer technical assistance and it still benefits the State. I think we missed the boat on non-State grant moneys being more responsive to the States' needs, because the States don't have much input into HEW or the National Center on how other kinds of technical assistance money and research money should be spent. Yet such money really also affects the people within our State.

Senator CRANSTON. So your State could use two or three times the present sums?

Ms. PRESSMA. Easily.

Senator CRANSTON. You all say yes to that?

Ms. SABOL. Yes.

Senator CRANSTON. Dr. Shaw, what do you think about the formula?

Dr. SHAW. I don't quarrel with the formula, but I would like to see, as I mentioned, money that has been funneled through third party contractors to come in and help us given directly to our agencies and departments; have it funneled into child welfare so we can determine our own research projects. I don't think I would like to see the research cut, which I think is very important.

Senator CRANSTON. One last question: When there is a report that comes in of child abuse or suspected abuse, what happens in your State?

Dr. SHAW. There are several entry points in our State. The report could go directly to our toll free hotline in Richmond or one could contact the local protective service, which is open 24 hours a day. There is a protective service worker in the area and that worker has to, within 24 hours, make a report as to whether there is anything to it and submit a report to the central bureau in Richmond. A followup within 14 to 45 days in each case is required. The services are provided, of course, if found necessary, immediately.

Ms. SABOL. This is somewhat similar in Kansas. Before I speak to that point, I would like to go back to an earlier one and that is the fact all funds coming through the States are pegged to the private contract and if we are really to effect coordination the designated State agency really must have some input and some controls over that in the State; otherwise you cannot effect coordination in the State.

In terms of what happens to a report, we do not have a hotline in Kansas. Reports can be made either to the juvenile court or public welfare agency. Ninety-nine percent of those reports go into the public welfare agency. Our law specifies we must respond within 24 hours and, generally speaking, that is what we do. We make some assessment of the damage to the child and what is needed in the family, develop the appropriate case work plan and then follow through on that plan, either providing the service directly or with our contract.

Ms. PRESSMA. In Connecticut the report generally in the daytime comes directly to the regional office, the mandated agency of the State. The hotline I referred to is open in the daytime, but it becomes especially important on week ends and evenings. Once the report is in, it is always investigated. What honestly truly happens is that after initial investigation only the more serious cases do get serviced immediately. The most frequent service, if there is imminent danger, is to remove the child. We do not have the resources within our State or the ability to change our State delivery system to keep children home during crisis. Change means money. Without new money tight fiscal conditions force the State delivery system not to change its designed service and type of resources it offers. We don't have funds for live-in emergency homemakers or immediate day care. Those are the kinds of resources that keep the family together and the States just don't have it. So, we take what we do have: We move the kids. Once the child is placed in foster care he stays too long or never returns home. The efforts in working with the natural family diminishes, not because the social worker wants it that way, but you have unreal caseloads and children just get lost in the system. I also think we missed the point of treatment—and this is every State, not just Connecticut—because we treat the child with his child psychiatrist in a residential setting and the mother or father with their psychiatrist back home and we never put the family back together for family therapy. Then we reunite them a year later and there is abuse again and we can't figure out why. It is in the interaction between the parent and child that you have to treat abuse and severe neglect to provide the necessary rehabilitation.

Senator CRANSTON. Thank you. You have all been very helpful and I appreciate your testimony a great deal, and also that of the others, and the interest and attention of everyone.

We will recess now and this subcommittee will meet again on the same topic tomorrow at 9:30 in room 4232.

[Whereupon, at 12:50 p.m., the subcommittee was recessed, to reconvene at 9:30 a.m., Thursday, April 7, 1977.]

EXTENSION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT

THURSDAY, APRIL 7, 1977

U.S. SENATE,
SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT,
COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to recess, at 9:40 a.m. in room 4232, Dirksen Office Building, Senator Alan Cranston [Chairman of the subcommittee], presiding.

Present: Senators Cranston and Hayakawa.

Senator CRANSTON. The hearing will please come to order.

This morning is the second day of hearings by the Subcommittee on Child and Human Development on Extension of the Child Abuse Prevention and Treatment Act.

Yesterday the subcommittee was privileged to hear a number of excellent witnesses provide both informative and moving testimony on the questions of how to prevent, identify and treat child abuse. Some of the country's leading authorities in the field told the subcommittee that child abuse and neglect continue to be a widespread phenomenon in our society, and that efforts to prevent, identify and treat the problem should be continued and improved.

We were particularly touched by the testimony we received from two parents—one who said that she had come very close to abusing her child and another who was actually convicted of child abuse. These courageous parents illustrated most effectively the human side of a problem which confronts thousands of families and which requires a strong and sympathetic response by Congress.

Today, we will hear from representatives of the Department of Health, Education, and Welfare which administers this act; and from representatives of several organizations which have been monitoring the activities funded under the legislation.

The purpose of these hearings is to determine how we might most effectively extend and possibly revise this program.

It is my hope that the witnesses who testify today will help us explore a number of issues which have been raised in recent months and were discussed at yesterday's hearing. These issues include:

One: What priorities should be reflected in the legislation? What percentage of the resources should be directed to research, to training, to demonstration efforts, to services?

Two: Should we place more emphasis on the prevention of child abuse? Is it in fact possible to prevent child abuse, and if so, how?

Three: What role should the States play in the program?

Four: What have we learned from the research thus far supported? How can this be reflected in our programs and policies?

Five: Has the National Center, in implementing this legislation, carried out the intent of Congress?

Six: Should we propose a simple extension of the program for 1 year in order to provide time for planning for improved coordination of all children and family services in the Department of Health, Education, and Welfare? Or, should we enact a bill which would incorporate substantial changes which may take several years to implement?

Our first witness will be Hon. Arabella Martinez, Assistant Secretary for Human Development.

Arabella, I welcome you once again to the subcommittee. I am glad you are here again and I look forward to working very closely with you on this and other matters that involve both our interests and responsibilities.

STATEMENT OF ARABELLA MARTINEZ, ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT, DEPARTMENT OF HEALTH, EDUCATION AND WELFARE; ACCOMPANIED BY SAUL ROSOFF

Ms. MARTINEZ. Thank you very much, Senator.

Mr. Chairman, I would like to place the bulk of my testimony in the record rather than go through it completely and just highlight some of the items in that testimony.

Senator CRANSTON. Fine, the full text will appear in the record at the conclusion of your testimony.

Ms. MARTINEZ. I am very pleased to come before this Subcommittee on Child and Human Development and I want to tell you that I am deeply concerned about this problem of child abuse and neglect.

As you know, I recently came to the Federal Government and, therefore, have not had the personal experience of dealing with the child abuse and neglect program during its first 3 years. Hence, I will present for the record a statement which gives an overview of the activities under Public Law 93–247 of the National Center for Child Abuse and Neglect.

Public Law 93-247, the Child Abuse Prevention and Treatment Act, is a response of the Congress to a growing concern over the abuse and maltreatment of young children. It created a Federal focus of activity directed toward improving the capabilities of all levels of government as well as citizens to prevent, identify, and treat child abuse and neglect.

Three-quarters of the appropriations over the past 3½ years have been used to sponsor research and demonstration designed to test knowledge of the field and improve treatment techniques. We are also conducting a study to determine the true incidence of child abuse and neglect as required by the act. Our demonstration program for which 50 percent of the funds provided under the act are spent, includes 26 demonstration treatment centers, varied in design and widely distributed throughout the country; our grants to Parents Anonymous, a self-help organization, have helped it grow from 50 to 500 chapters helping over 5,000 parents deal with their family problems. We also have established 16 regional resources projects to provide technical assistance and training to States and local communities.

Each year we allocate a maximum of 20 percent of our funds to States. They must meet certain requirements in order to qualify for this money and the number who qualify has grown from 3 in 1974 to 29 in 1976.

States have used this money to provide a variety of innovative programs ranging from hotlines to public information campaigns to the establishment of special clinics. In addition to these activities, the Center also operates an information clearinghouse, has developed training materials, and conducted many training programs.

It has provided technical assistance materials and has worked with the advisory committee to develop Federal standards of good practice. These standards are now being reviewed prior to issuance.

As this brief overview indicates, the National Center has been engaged in a number of positive efforts. While I would not go so far as to say it has all been perfect, my general assessment is that we are doing a fairly good job.

However, I do wish to take a closer look at the organization and focus of the program and, therefore, request a 1-year extension during which we will determine what changes would be appropriate in the program. I would like to speak a little bit about the general focus that the Office of Human Development is taking and put the child abuse and neglect program in that context.

Since I have been in the Office of Human Development I have realized, as I never realized before, that we do not have a national public policy on social services, not for children, youth, families, the aged, or the handicapped. We have a series of fragmented programs which address special needs.

Some of those programs are extremely specific as to what the agency has to do. As a result of doing an analysis of the Office of Human Development and beginning to project what we would like to accomplish to make that a more effective government operation we have begun to develop what I call a National Public Policy on Social Services, and we are still very much in the thinking and conceptual stage and we are talking to many citizens across the land about this because we desperately need their wisdom and knowledge.

We would like very much to develop a social services program based on four concepts: (1) We would like to work with the whole person and not just pieces of an individual; (2) we would like to strengthen families, whatever the family unit is like; (3) we would like to help build supportive community institutions—people receive their social services in communities and we would like to strengthen and develop new community institutions to provide services; and (4) we would like to help to contribute to the development of livable communities. We can provide income support and social services, for example, to any one of our clients but if they are both afraid to stay in and to go out then you haven't done very much for them.

The fifth concept, which is of a different nature is that we would like to really address the delivery system mechanism. I am deeply concerned that very little of the social services dollar gets to the client, so we would like very much to begin to build efficient, effective and accountable and compassionate delivery systems. We do not have those in place. We really need to address that issue aggressively.

In terms of the Office of Child Development, we have a Headstart program, which is fairly broad in terms of its concept of child development and has done a good job with limited funds it has and limited geographic distribution. And we have a child abuse and neglect program which is mostly a research and demonstration program, although the demonstrations do provide social services.

And we have a child welfare section which basically does advocacy in terms of such issues as adoption and foster care. But we do not have an Office of Child Development. We have a series of programs under a rubric called the Office of Child Development.

These are the issues which the administration would like to have time to look at to see how we might strengthen our services to children, youth and families, and that is why we ask for an extension of the legislation rather than any amendments.

That's all I have to say, Senator. I will be delighted to answer questions.

Senator CRANSTON. Thank you very much. I am very impressed by that outline of the policy that you would like to see developed. It would certainly be marvelous to develop it and it could be effectively implemented to take into account the various needs you outlined and see that the programs are fit into an overall framework.

If there is anything we can do to help bring that about I would certainly like to be of assistance.

I do have quite a number of questions and if any of them ask for information that you just don't have at your fingertips, written responses within the not-too-distant future will be helpful for the record.

First: According to the best information available to the National Center, how many children would you estimate are abused or neglected in this country, and do you thing the incidence is rising?

Ms. MARTINEZ. I would like to have Mr. Saul Rosoff answer that, but I would like to say something about the rising incidence. I am not sure we can say the incidence is rising. I think what we have to say is that as a result of our program, and as a result of the legislation we are much more aware of the incidence and, in fact, the suggestion that the incidence is rising says something about the effectiveness of the program in identifying the case of child abuse and neglect.

As to numbers, I will let Mr. Rosoff answer that question.

Mr. ROSOFF. Based on data that we received from a number of reporting States and also some other studies, and this is very conservative, we believe there are approximately a million children suffering from abuse and neglect, and of those, at a minimum it would be 200,000 suffering from abuse. This is a very conservative figure.

Senator CRANSTON. When did we start getting any figures at all on this?

Mr. ROSOFF. We started getting figures about 3 years ago. At that time, we put a system into place to help States establish uniform reporting system through an agreement with the American Humane Association. They have worked with States to assist States in developing a common reporting format and to encourage States to provide data. At this time there are over 30 States that are part of the system. The States have found the assistance in providing forms and definitions available to them very useful because for the first time in some cases, a framework for reporting has been provided.

This is based on the latest input from the States.

Senator CRANSTON. There were no figures at all 10 years ago?

Mr. ROSOFF. There have been a variety of studies, as you know, on the incidence of child abuse. Estimates have ranged from several million to much lower figures. There is, unfortunately, not the kind of hard data which we believe we will be developing in the near future.

Senator CRANSTON. Are you familiar with the study of family violence that was presented to the committee yesterday by Professor Gellis?

Mr. ROSOFF. Yes; I have some awareness of this.

Senator CRANSTON. What is your reaction to it?

Mr. ROSOFF. I believe he has done some very useful work but, as he has pointed out, the data is very preliminary. He is developing the data further and his data implies a much greater potential incidence of abuse than the data cited above. He does not deal with neglect and we will be working with him in the coming months to look at his data and see to what extent we ourselves can profit from his studies in terms of arriving at national projections.

Senator CRANSTON. If the preliminary results of that study are accurate, what implications do you see from that in regard to our considering this act and amending or extending?

Mr. ROSOFF. It is very clear that there are a very large number of children in this country being neglected and abused. Reasons range from social stress, family problems, lack of understanding about parenting, economic problems, a history of the parent being abused, and other factors.

As has been cited, there is a need for much research. There is a need for many services. There is a need for much better data if we are to, in fact, be able to come to grips with this problem.

Senator CRANSTON. You stated you favor a 1-year extension of the act for the reasons advanced. As you know, this subcommittee has taken no position on that yet. I understand that our colleagues in the House are going to propose the act be extended for several years.

If we did just 1 year probably the end result would be an extension of at least a 2-year period when we went to conference with them to iron our differences. Faced with the reality of something more than 1 year as rather likely and taking into account the fact you prefer to add no amendments, but given the fact we may have a 2-year-or-more extension, do you have any changes you think perhaps should be made in the light of that circumstance?

Ms. MARTINEZ. We have discussed some changes and I think if there were going to be a 2-year extension rather than a 1-year extension, we certainly would want to work with your committee to work out those changes. We have some suggestions but they are very minor at this point.

Senator CRANSTON. If you don't have those suggestions now we can perhaps pursue them together between your staff and my staff and ourselves.

Are there any activities supported under the act which you think no longer should be funded? As an example, should the Federal Government continue to be involved in activities like training curriculum development and public awareness campaigns in your opinion?

Ms. MARTINEZ. I think so. I don't think we have enough trained people and we are not necessarily talking about professionals in all cases. We are talking about lay people. Also, we are talking about schoolteachers, we are talking about social workers, we are talking about police, we are talking about doctors who are professionals but they are not professional necessarily in relation to the problems of child abuse.

I think if we are going to really address the problem of child abuse and try to prevent it we must have people able to identify it and not identify it wrongly so that parents are accused of child abuse and neglect when it is not true. So, you need to have good training and a lot of people trained.

Senator CRANSTON. I understand the demonstration programs have been funded through fiscal 1977. Is it your intention generally to extend funding through fiscal 1978 to those that have been effective?

Mr. ROSOFF. The present rules relating to demonstration grants limit them to a 3-year period. To extend any of the existing grants past that time we would have to find ways to make some changes in the rules governing the award of demonstration grants, and also to make some other kinds of qualitative judgments.

Senator CRANSTON. Are those your own regulations?

Mr. ROSOFF. They are regulations issued as the departmental policy of HEW relating to demonstrations.

Ms. MARTINEZ. They are department regulations. But, I think if we are going to ask for an extension of 1 year then we ought not to go funding new demonstrations.

Senator CRANSTON. The question is what is done about continuing the present operations? How would you intend to spend the funds which would become available if the current appropriations level is maintained for fiscal 1978 as the administration has requested?

Ms. MARTINEZ. As you know, the legislation is very tightly drawn and it really tells you how you spend your money. My assumption is that we shouldn't go out into new directions if we are only asking for a 1-year extension.

Senator CRANSTON. Would you expect then to continue funding present demonstration projects?

Ms. MARTINEZ. If we can change the departmental policy.

Mr. ROSOFF. We need also to look at the quality of those demonstrations and some other demands being made of some very useful other kinds of things which might be funded.

Senator CRANSTON. There is no way you will be able to spend the money presumably, unless it is on new projects and old demonstration projects; 50 percent is earmarked for that specific and sole purpose.

Would you summarize for the subcommittee the Center's program plan for the next year or two? I think probably if you give a detailed answer in writing it would be better.

Mr. ROSOFF. Basically, the law indicates a number of areas which would be addressed. In the area of research there are a number of questions we would want to look at. Among these, what are the most effective approaches to treatment, what can be done to assist in defining various kinds of cases so that people can appropriately deal with them, what can be done to assist people, professionals and other individuals to identify cases of child abuse, what are the major problems encountered by caseworkers, and what can be done to, in fact, assure the better linkages to services for the children.

Those are some of the areas in research that we would be looking into. In addition, we would look at the kinds of testimony that has been presented, and would speak with persons in the field to see what is most useful and most valuable to do in a relatively short period of time. We would continue our information clearinghouse activities. We have found we have been able to bring together over 1,000 citations on work being done and we are receiving, I believe, almost 800 inquiries per month about child abuse.

As you know, the act has been fantastically successful in bringing an awareness to this country of the problem and of some things which can actually be done. In the area of training, we won't be developing any more materials. We feel we have developed a very successful and useful supply of materials for training. There is still a need to continue working with people to provide training, and in a number of cases we are working directly with the States and in some cases turning training and technical assistance funds over to the States to enable them to handle these issues.

We will continue our incidence study as has been discussed. It is very important we have a base of data and a dependable base. We need a dependable base that people can depend on and upon which social policy can be developed. It is also important in the area of demonstrations that we continue to the degree we can the most successful projects.

We also would look to see what other kinds of demonstrations can be funded. We would look at what other arrays of preventive and assistance services can be gathered and presented in the most effective manner to deal with sexual abuse. How can we best deal with that? There are a number of areas which need to be addressed. We will provide more information for the record.

Senator CRANSTON. I know one of the reasons you advocate a 1-year extension of the act is, as you outlined, you hoped to better integrate services for child abuse efforts with other children and family programs generally in the future. Can you give us any sort of preview. We are thinking about how this program should relate to the services presently funded under title XX and IV-B of the Social Security Act. Both of those are under your jurisdiction as I understand.

Ms. MARTINEZ. As you know, Senator, title XX and IV-B are basically block grants to States. States really set the priorities in terms of the social services they provide and they essentially set their own rules and regulations about how those services should be provided.

I am concerned that we begin to give States more leadership and more direction in terms of our knowledge base. I think, if we could work with the State governments with respect to the kind of information we are gathering about the best way to work within the field and to prevent abuse and neglect, that there would be better programs at the State level.

But, it will take some time to put into place a technical assistance support mechanism to work with States on title XX and IV-B. It is a very complicated issue, as you know, because it relates to the whole Federal role and Federal-State relationships.

Senator CRANSTON. Some critics suggested the center does too much on reporting incidents of child abuse and neglect and not enough followup in services when that is known to occur. Do you have any comment on that, please?

Mr. ROSOFF. We are basically carrying out the elements of the law. The law really does not speak to our providing services. We do encourage States and localities to provide the kinds of services they can. In encouraging in reporting, we naturally try to make sure in our recommendations that personal privacy is safeguarded. We can't, from our level, provide service funds, although we do have demonstrations which show the difference services can make to children and to families if there is a proper array of both counseling services and other services available to families.

Senator CRANSTON. Do you think the law doesn't really provide enough direction in terms of services?

Mr. ROSOFF. In terms of services I think there would need to be made a judgment as to what is the appropriate role in terms of providing services under this kind of an act compared to other kinds of legislation that might exist and to how the services might be provided. This is obviously a very complex issue which would need to be addressed.

Senator CRANSTON. Arabella, if you would look at that particular aspect of this and get back to us in writing later.

Ms. MARTINEZ. I said earlier the law is very tightly drawn as to what we must do and, in essence, we really cannot provide service excepting through the minimal grants we make to States and through demonstrations. That is part of the problem of the way the law is drawn.

Senator CRANSTON. If you take a look at that aspect and come back with some thoughts in writing I would appreciate it.

What are the respective roles of the local and State jurisdictions and the Federal Government in this area?

Ms. MARTINEZ. The place where people get service is at the local level and we ought to strengthen the local community's capacity to prevent child abuse and neglect and to provide services in this area.

I think the role of the Federal Government and of the State government is to provide leadership, direction, knowledge, expertise, technical assistance, but the services should be provided at the local level. It is one way of not separating children from their families.

Senator **Cranston**. Of course the area of Federal funding is an important part of our Federal role. Only about 30 of the 50 States so far have qualified for funding under the State formula program. Why is that?

Ms. **Martinez**. There are some very stiff requirements in the law as to how the States qualify.

Senator **Cranston**. Do you think they are too rigid?

Ms. **Martinez**. I do not think they are too rigid. I think it is necessary to have requirements. But, I think it is amazing that in 3 years we have come as far as we have come with the States. We anticipate that there will be a number of new States coming into compliance with the regulations this year.

We started out with three, 3 years ago. We now have 29. I think we expect 38 by the end of this year and I think that is an amazing kind.

Senator **Cranston**. I think California is amazed that it hasn't qualified yet.

Ms. **Martinez**. Senator, maybe we ought to go back there and show them how.

Senator **Cranston**. Do you think there should be any changes in the criteria, based on your experience?

Mr. **Rosoff**. I think the experience has been a very useful and valuable one. The Congress was very careful in the criteria it listed. The net result is that States that have come into compliance clearly have more effective neglect and abuse programs than they would have had otherwise.

Senator **Cranston**. Quite a few people proposed that in the renewal of the legislation we increase the percentage of funding available under the State funds from the current maximum of 20 up to as high as 50 or even 75 percent. What do you think of that?

Ms. **Martinez**. I think at this point in time that would be not a wise decision, primarily because it would mean we would eliminate a lot of the research work that needs to be done, and a lot of the demonstration work that is being done. I do not know that we shouldn't change the formula ever. In fact, I think we need to address that issue very aggressively at the next round.

But, at this point I don't think we ought to change the formula because we still don't have the kind of information and the research, the good research, the hard data that we need. But, I think one of the major areas that we need to look at in the future is changing that formula on how much money goes directly to the States.

Senator **Cranston**. If we are not going to do much in the demonstration projects it might be possible to get more money for other activities and certainly, you don't want it all to go into research by any means, do you?

Ms. **Martinez**. No; I don't believe you should have it all in research. I think the initial reasoning was that we were so lacking in information and we still don't have it all, but I think we have advanced a great deal in our information base. It would mean that there would be more direct services for children if you changed that formula. But, in many ways our demonstration programs do provide direct services now.

Senator Cranston. The money that is presently made available for demonstrations if we are not going to be going into that field, that would free money either to help the States or for additional research. I presume you wouldn't want all that to go to research. Why don't you think that out.

Ms. Martinez. That is one of my great concerns, that formula.

Senator Cranston. What is the backlog of approved or approvable unfunded applications for research grants and for demonstration projects? Do you have a figure?

Mr. Rosoff. None. There is no backlog. Our last grant solicitation was sent out approximately a year-and-a-half ago. We funded those that we could, based on available funds and rejected others that had not been approved or for which we had no funds.

I believe we received over 600 applications during the past several years for research and demonstration. I believe we only funded about 12 percent of all those.

Senator Cranston. Would you give us, for the record, a breakdown showing the amounts in both research and demonstrations? Information prepared by HEW at the subcommittee's request shows that $3.1 million funding to the State programs have been approved. However, only $1.3 million, less than half the amount approved, has been spent by the eligible States. I would be interested in why, in your opinion, those funds have not been spent and what has happened, in light of the testimony we received yesterday, the States are asking for additional funds.

Ms. Martinez. I gather the reason the States have not spent their money is they seem to have difficulty initiating projects promptly, partly because of limitations by the State civil service requirements. There are other States that, once they got the money, changed their plans. Also, some programs really were delayed because they were on their own fiscal years, and held up until their fiscal year began.

Also, in some States there was a need for legislative appropriation before the program became operational and caused delays. Also, it just may be when States are starting new projects, they have difficulty in using the money right away.

Senator Cranston. Are there particular models of service which have been successful and should be replicated?

Mr. Rosoff. Out of our demonstrations we will be coming up with a number of suggestions. It is very clear that the kinds of models need to show how to bring services together, how to bring people from different disciplines together to deal with cases. Also we need to show how to make certain kinds of resources available, how to provide assistance in prevention programs. These are all elements of good programs which we will be able to identify.

Senator Cranston. Would you favor including a provision in the bill placing special emphasis on making grants for projects which replicate projects that have demonstrated their effectiveness?

Mr. Rosoff. There is a large demand out there both for that kind of replication and also for the undertaking of new demonstrations and new research. We would have to balance those kinds of things within the resources available.

Senator Cranston. The subcommittee is concerned about reports that suggest that the Center may have used its limited funds in such a way as to produce unnecessary duplication of efforts to some extent in this field. I would appreciate it if you would address two examples that have been raised; one is your funding of a national media campaign to create public awareness of the problem of child abuse and at the same time a similar campaign is being conducted by a private organization, the National Committee to Prevent Child Abuse. Do you know the cost of each of those campaigns, the Center's and the other? Did you consult with the National Committee before proceeding to obligate Federal funds?

Mr. ROSOFF. We have worked with them. We have been aware of their activities and they have been of ours. I can provide more information for the record in terms of actual cost of our programs.

Senator CRANSTON. Would you do that? I wish you would explain one thing. Why did you need it?

Mr. ROSOFF. I think you will find they have different elements and different publics. Let us develop that in detail.

Senator CRANSTON. Fine. The second example—maybe you will want to respond in writing to this also—it concerns the funding of the study required by the law to determine the incidence of child abuse and neglect and whether it is increasing. If you can tell the committee how much money has gone to the American Humane Association and to private contractors for this purpose and explain the tasks assigned to each of those recipients. If you would prefer to do that in writing, I understand.

Mr. ROSOFF. Yes; I have some of that data available here. I think in writing we could provide it in much greater detail.

Senator CRANSTON. Fine. When the Congress required the incidence study it hoped to receive the results in time for consideration in connection with the renewal of this bill. It is clear that we won't have anything for some time. Do you know why that is?

Mr. ROSOFF. We originally started off and had a small feasibility study as to how we can gain information on incidence. We found a number of problems in some of the results in terms of the kinds of approaches that might be used. We also had some useful information in it and, being very cautious and very concerned about the importance of this kind of undertaking, we decided to undertake a further study of potential approaches in gaining an insight into incidence.

We now have a study underway that by the end of the year will give us some sample approaches in terms of the possibility of using household volunteer data, data from States and the advantages and disadvantages of those and other approaches. Based on that study, we will be in a much better position to make both fiscal decisions and programmatic decisions as to the next steps. This is one of the most important things we are doing and it is crucial that it be done well.

Senator CRANSTON. How much has been expended thus far in this effort?

I mean Federal funds.

Mr. ROSOFF. In terms of Federal funds $100,000 was expended on the initial effort. Approximately half a million dollars is being expended in the present effort. At this point, I believe the total is between $600,000 and $700,000.

Senator CRANSTON. I am surprised it has taken so long. We enacted that in 1974. I know you are pioneering. It may be very hard to get data. How many job slots does the National Center have?

Mr. ROSOFF. The Center has 15 positions at headquarters and 13, I believe, in the field.

Senator CRANSTON. Are all those filled at the present time?

Mr. ROSOFF. I believe there are two vacancies of that total.

Senator CRANSTON. Why are they empty and how long have they been empty?

Ms. MARTINEZ. Senator Cranston, as you know, there is a freeze across the Federal Government in terms of hiring. We are not able to fill positions at this time in any of our units.

Senator CRANSTON. Can you give us a list of the job descriptions and salaries, not the names but the roles assigned?

Mr. ROSOFF. Certainly.

Senator CRANSTON. How many people do you think are really needed to do the work?

Mr. ROSOFF. I believe when we were first looking at undertaking the responsibilities of the act we estimated somewhat of a larger number than we finally ended up with. Of course, we were able to carry out the intent of the act within the resources but our original estimates were larger in terms of providing more adequate activity. We can provide more information if you would like for the record on that.

Senator CRANSTON. If you could give us some idea of the workload for project officers managing your grants and projects I would appreciate that for the record. Also, if you could tell us in writing how many separate grants and contracts would each officer be monitoring and the approximate dollar amount monitored by each project officer. I would like your judgment as to whether that is consistent with the general work load within the Department of HEW or is it a heavier load than elsewhere.

Shortly before the Child Abuse Prevention and Treatment Act was signed the Department of HEW announced it would spend about $4 million on various projects related to child abuse and neglect. What has happened to those projects?

Mr. ROSOFF. This was a joint effort where funds from the Office of Child Development, the Public Health Service, the Office of Education, and the Social and Rehabilitation Service were pooled. We came up with a common framework to undertake numerous projects.

One example is the Office of Education where they did quite a bit of work in terms of working with school systems to provide informational material as to how they can best be alerted to potential cases of child abuse and neglect.

There was also joint funding of approximately 11 demonstrations to show different ways of providing approaches to assisting families. We will have some of that latter data, I believe, within about 6 to 8 months. There was also several independent studies relating to some very specific kind of training.

We can provide you, for the record, with fuller information.

Senator CRANSTON. Have you made any effort to stimulate programs or expenditures elsewhere, like at NIH or NSF?

Mr. ROSOFF. An interagency group that has been established. Within that group there is discussion of what the needs are relating to child abuse and neglect. There is discussion also of what the various programs do and review of projects that have been funded. It is basically up to each area as to what they will fund.

Senator CRANSTON. If you would give us for the record a summary of what is going on in those other agencies, what they are spending on them and what efforts are made by you in bringing that about I would appreciate it.

Mr. ROSOFF. Certainly.

Senator CRANSTON. Is it true, since the enactment of this law other agencies in HEW have withdrawn the supportive efforts relating to child abuse and neglect?

Mr. ROSOFF. I would estimate that other agencies are probably putting in less resources today than they were several years ago. We would have to look to make sure.

Senator CRANSTON. Why is that?

Mr. ROSOFF. I believe they would have to speak for themselves on this matter. There might be a feeling that, since there is now an act and money specifically assigned that they might want to fund what they consider to be higher priorities in their own areas. I obviously can't speak specifically for those agencies.

Senator CRANSTON. If you give us a list of other agencies in HEW and elsewhere in other Federal departments supporting activities related to child abuse and what they are doing that would be very helpful.

Mr. ROSOFF. Yes, sir.

Senator CRANSTON. If you could tell us what kind of projects are underway and how much each agency spends.

What has the National Center done to coordinate its efforts with the study funded by the National Institute of Mental Health on family violence we were told about yesterday? Are you familiar with that?

Mr. ROSOFF. Yes. That study was funded before our Center was established, but we have been aware of the work being done and we are aware through this interagency group of the various projects that are carried on in child abuse by other agencies.

Senator CRANSTON. Do you know what percentage of funds spent under this act have been awarded to profitmaking consulting firms and what percentage nonprofit entitites?

Mr. ROSOFF. I believe approximately between 12 and 14 percent have been awarded to profitmaking firms. Let me provide the other data for the record.

Senator CRANSTON. What steps has the Department of HEW taken to assure the quality of research conducted under the act?

Ms. MARTINEZ. Senator, we had a meeting just yesterday on the management of research within the Office of Human Development and we are looking into the whole area, not only of the management of research projects but the awarding of contracts.

As you know, this is an issue which is being discussed in all Federal departments at this point, and we are very much involved in looking at our own contracting operations.

My assumption is there has been certainly some control previous to this time but we want to make sure we are getting what we are paying for.

Senator CRANSTON. Is there any formal mechanism where some other part of HEW or someone at NIH wants to do research in this field that they check in with you before they undertake it?

Mr. ROSOFF. Through the interagency group that was established by the law there is discussion of what various agencies would want to undertake. There is also an interagency research group that meets and discusses total children's research needs and exchanges information as to what the needs are and what needs to be supported.

Each agency basically can fund its own research without a programmatic decision oversight by the committee.

Senator CRANSTON. When there is an actual grant application and consideration is there any formal mechanism to coordinate with your efforts?

Mr. ROSOFF. There is no mechanism that mandates that this be done prior to the award. There are mechanisms that mandate that after the award has been made that information be shared.

Senator CRANSTON. Arabella, wouldn't that logically be the Secretary? Might it not be logical to advise the Secretary?

Ms. MARTINEZ. The Secretary is developing a lot of management systems in a lot of different areas and he has great concern about duplication. I will certainly advise him of your concern.

Senator CRANSTON. If you could let us know what happens in the course of time on that, I would appreciate it. Do you think there should be NIH type peer review or advisory council reviews of research applications?

Ms. MARTINEZ. We do have a panel for the Office of Child Development. There is a research panel which reviews all applications on research. They rate these applications and then, after they rate the applications they go to our contracting office, which is separated from our program units to assess them in terms of their costs and the requirements of the law for contracts. There will be new members coming on this panel and we are hoping that we will have a real affirmative action panel, one that is composed of many different racial and ethnic groups.

Senator CRANSTON. When this bill was considered in the Senate back in 1973, it contained a provision for creation of an advisory committee to monitor the activities of the National Center. That provision was deleted at the request of HEW before the act was finally put into final form.

Yesterday, a number of witnesses expressed deep concern about the quality of research presently being conducted under the act and proposed the creation of such an advisory committee as a means of improving the quality of that research in the future. What would be your reaction if Congress did require the renewal of the creation of such an advisory?

Ms. MARTINEZ. We are studying the committee system within all the Federal agencies, but especially in HEW because we seem to have so many committees. I think we would want some time to think about that. I think the idea of having outside reviewers to insure the quality of research is extremely important. I do not know that necessarily requires a committee but I think we need to explore the idea of having panels of people who are brought together to look at our research.

Senator **Cranston**. Senator Hayakawa, I should have turned it over to you a little bit earlier. Do you have any questions?

Senator **Hayakawa**. No.

Senator **Cranston**. I have just one other question. Is it possible, within the limits of the Child Abuse Prevention and Treatment Act to place greater emphasis on prevention of child abuse and could the Center carry out that responsibility? How would it do so?

Ms. **Martinez**. I think in some ways the whole act is oriented toward prevention in the sense of the whole identification and the public awareness campaigns. I think we ought to work more closely with the families who are at risk. I think we could add some additional prevention ideas in there but I don't think a change in the legislation is necessary. I think it can be done administratively.

Saul, you might want to respond to that.

Mr. **Rosoff**. Our activities have really only touched upon perhaps secondary prevention; the dealing with trying to help the child and the family after it happens. As we look at the causes it is very clear there are a number of causes—if we are very serious about prevention, there are a number of things which we recognize have a role in bringing about abuse and neglect.

One factor is the entire kind of stress families are under, economic stress, poor neighborhoods, the whole area of the family stress, economic and other kinds of situations. Another concern in terms of prevention relates to the identification of assistance that could be provided in term of alleviating certain kinds of stress, like day care programs.

Very often, if a family, a mother, a father could have a place to bring their child when stress becomes overwhelming whether it is a neighborhood center or other type of help, those kinds of help would make a difference.

Thus, there are many things which, if we are serious about prevention, could make a difference. The question is, within the present law to what degree can those kinds of things be carried out, but there are things which can be done.

Ms. **Martinez**. Senator, one of the things, of course, the administration is very deeply concerned about is the family. If we can begin to be involved in strengthening families, that is going to help with the prevention. I think frequently our programs have, instead of strengthening families, have weakened families. So, it is a broad issue that cuts across all of the various problems which children and youth face.

Senator **Cranston**. Let me just ask generally, do you have anything to add to what you have already said about how you evaluate programs funded under the act and what conclusions you have drawn from those evaluations? If you prefer, you can do that in writing.

Mr. **Rosoff**. We do have evaluation mechanisms. We will provide that in more detail.

Senator **Cranston**. If you can indicate in writing what conclusions you have drawn up to now on those evaluations I would appreciate it. Thank you both very much.

Ms. **Martinez**. Thank you, Senator.

[The prepared statement of Ms. Martinez and additional material submitted for the record follows:]

177

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

ARABELLA MARTINEZ
ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT

BEFORE THE

SUBCOMMITTEE ON CHILD & HUMAN DEVELOPMENT
COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE

APRIL 7, 1977

I am pleased to come here today to discuss the Child Abuse Prevention and Treatment Act of 1974, and to urge one year extension of this important legislation. While my remarks focus on describing the implementation of the Act by the Office of Child Development of the Department of Health, Education, and Welfare, I would like to place the discussion in historical perspective so that recent progress can be fully appreciated.

INTRODUCTION

In the past few years, there has been a sharp increase of professional and public concern over the abuse and maltreatment of young children. As a result, impressive progress has been made in our ability to protect the abused and neglected child and to assist his family. But there still are substantial gaps between what we want to do to protect children and what we can do. Much more needs to be known about the causes, the nature, the extent, and the best ways to prevent and treat child abuse and neglect, including sexual abuse. And we want to be sure that the whole child and his family receive all of the necessary supportive services from the community in which they reside.

Child abuse and neglect derive from a wide range of social and psychological problems that cannot be managed by one discipline or one profession alone. Social workers, physicians, nurses, lawyers, judges, psychiatrists, teachers and others must all work together if the cycle of abuse and neglect is to be broken. But helping efforts remain fragmented among various disciplines; communications and coordination are difficult to implement; and fear and hostility among competing agencies and approaches still exist.

Although all of our 50 States have child abuse reporting laws, the legal framework for child protective work, in most States, is incomplete and unnecessarily complex, thus making it difficult to implement effective programs. Moreover, in many communities, the financial and institutional support necessary to sustain adequate treatment and preventive services continue to be lacking. Child protective workers are generally not given the training, skills and ancillary services necessary to meet the important life-saving responsibilities assigned to them. Too often, the only treatment alternatives available to the child and his family are infrequent and largely meaningless home visits; overused foster care; and unthinking reliance on court action. Lacking suitable long-term treatment services, most American communities are faced with a grim choice in cases of serious abuse or neglect — either break up such families or leave the children at home where they might be seriously injured or even killed.

Overview

The Child Abuse Prevention and Treatment Act, through the National Center on Child Abuse and Neglect, created the first Federal focus to improve the prevention, identification, and treatment of child abuse and neglect by enhancing national, State, local, community, and citizen efforts to help the child and his family. Central to our approach has been a commitment to nonpunitive, interdisciplinary and community-wide treatment efforts, because we are convinced that child abuse and child neglect are social and psychological problems with roots deep in the way we live and in the way our society is organized.

In essence, we seek to focus Federal efforts relating to child abuse and neglect through activities directed toward the twin goals of: (1) generating basic and applied knowledge about the prevention, identification, and treatment of child abuse and neglect; and (2) providing general and technical information and limited program support to assist local communities in applying available knowledge to expand prevention, identification, and treatment efforts.

Three-quarters of the appropriations, over the past three-and-a-half years, have been used to sponsor research and demonstrations designed to test knowledge of child abuse and neglect. Each year, we allocate 20 percent of our appropriations for State grants. Because some States are not yet eligible, the actual expenditure for State grants last year was approximately 12 percent of the year's appropriation; however, in the future the entire 20 percent will go to the States. Another 10 percent of the appropriation provides technical assistance to States to assist them in meeting eligibility requirements and to public and private agencies dealing with abuse and neglect. Thus, approximately 95 percent of our appropriation is spent on research, demonstrations, State grants, and technical assistance which impact directly on the child and his family. The remaining five percent supports the child abuse and neglect Information Clearinghouse, various publications, and other miscellaneous activities.

Research Projects

Perhaps the most critical fact about the field of child abuse and neglect is the paucity of primary knowledge about its causes, nature, extent, and its prevention and treatment. We have funded 16 research projects which are exploring: (1) the factors contributing to abuse and neglect, including family, social, and economic stresses; (2) the relationship between drug abuse and alcohol abuse and child maltreatment; (3) promising preventive and treatment techniques; and (4) the means to measure and evaluate the effectiveness of programs.

Underlying much of our research is an attempt to clarify the complex relationships between psychological and situational factors (including the condition of family life) and individual behavior. For example, poverty is frequently cited as a stress on parents that leads to abuse. And yet we know that most poor families do not abuse or neglect their children.

We are also conducting a nationwide study of the incidence and severity of child abuse and neglect in the United States, as required by Section 2(b)(6) of the Act. At present, we estimate that there are approximately one million abused and neglected children in our country. Of these, about one-fifth are abused and the remainder are neglected, an omnibus term denoting parental failure to provide such basic necessities of life as food, clothing, and shelter. In addition, over 2,000 children die each year under the circumstances suggestive of child abuse and neglect. By giving us a more precise idea of the extent of child abuse and neglect, this incidence study will enable us to improve the allocation of limited service resources and, more importantly, it will help mobilize greater public support for needed treatment and preventive efforts by revealing the true magnitude of the problem before us.

Demonstration Projects

The law now mandates that at least 50 percent of our funds be spent on demonstration projects. To advance our state of knowledge regarding the provision of helping services, we have funded a number of demonstration projects geared to finding out what works and arranging for further use of effective techniques. We are striving to insure that the demonstration projects have an impact beyond their life as federally funded projects.

Twenty-six Demonstration Treatment Centers have been established which, if they prove successful, can be replicated elsewhere. These projects, in all parts of the country, are responsible for total case management within the context of the community-wide coordination of services. Most of the projects are using interdisciplinary teams of professionals to guide and coordinate their efforts. Depending on the project, they are performing child protective investigations, child and family assessements, and direct treatment (including group therapy, art therapy, and play therapy). Many are operating 24-hour hotlines for parent counseling. All of these projects are focused on the goal of keeping families together. Staffed by specially trained teams of professionals and paraprofessionals, these Treatment Centers are demonstrating what can be accomplished when staff have the time and resources to meet the needs of multi-problem, abusive and neglecting families.

Nine of these Treatment Centers address the problem of three kinds of families that are often not adequately served by existing systems -- Native American, military and rural families. Especially sensitive to the traditions and problems of the populations they serve, these projects are seeking to place child protective work within their client's cultural context.

We have also made a grant to Parents Anonymous, a parental self-help group, to increase its coverage across the country. Progress has been substantial. Before we assisted Parents Anonymous, there were fewer than 50 chapters, mostly on the West Coast. Their progress has far exceeded their original goal of 200 chapters. There are now over 500 chapters of Parents Anonymous in all parts of the country, helping over 5,000 parents deal with their family problems.

We have also established 16 Regional Resource Projects to explore how best to help States, localities and private citizens to assess, coordinate, and improve services. In response to State and local needs, they provide a diversity of training and technical assistance, including consultative services on case management and agency administration, and specialized training.

Each of the National Center's demonstration projects is being carefully evaluated -- by outside teams of experts — to determine what techniques work best and to convert this field experience into practical knowledge that can be used by others seeking to improve existing services or to initiate new ones.

Information Clearinghouse

As required by the Act, the National Center is developing and maintaining an information clearinghouse on all programs for the prevention, identification, and treatment of child abuse and neglect. The National Center is also disseminating the information it collects to all relevant persons and groups.

An increased interest in child abuse and neglect is reflected by the 30 percent growth in the overall number of publications on child abuse and neglect, in the past 18 months alone. The National Center's Information Clearinghouse has collected information on over 2,000 operating treatment programs and on over 1,500 publications and audiovisual materials. All of these materials have been abstracted and placed in a computer with on-line capability — thus giving an inquirer the capacity for almost instantaneous review and retrieval of information. Within six months, remote terminals will allow access to this data base from anywhere in the country.

In August 1975 the National Center submitted a report to the President and the Congress on the Implementation of P.L. 93-247. Each year we publish and update a summary of research entitled CHILD ABUSE AND NEGLECT RESEARCH: PROJECTS AND PUBLICATIONS and a summary of ongoing programs entitled, CHILD ABUSE PROGRAMS.

Training

In 1974-75, the National Center conducted a nationwide needs assessment which included that (1) there was an immediate need to train a core group of professionals and paraprofessionals in the diagnosis, reporting, and treatment of child abuse and neglect, and (2) suitable training curricula had to be developed as soon as possible for a broad range of professionals.

To respond to this need, we trained 1,700 professionals and paraprofessionals in a series of five-day conferences in all parts of the country. The training consisted of developing new skills in multidisciplinary teamwork and coordination among professionals in child protection, social work, health, law, law enforcement, and education. Our Regional Offices and Regional Resource Projects annually train an additional 12,000 people.

In the long run, however, training must be a local responsibility tailored to fit local needs and local practices. Therefore, we developed a multidisciplinary curriculum package for use by local trainers. The curriculum is currently being field tested by 22 training grantees and by 16 Resource Projects. In its first year of use, we expect that over 10,000 people will be trained with the assistance of this curriculum package.

Technical Assistance

Our technical assistance activities are designed to leave a lasting impact upon those who receive our help through the use of model, or prototype, materials for local groups and agencies. Some of these materials are targeted for special audiences, such as the nation's children's hospitals, and some have been on specific activities, such as public awareness campaigns and the upgrading of central registers of child protection cases.

Because an informed and supportive citizenry is crucial to effective treatment services, we have developed posters, model newspaper advertisements, and radio and TV spot messages individualized for local agency use. They are being used or are planned to be used by over 30 States in the coming year. These materials seek to go beyond the sensationalism of ordinary media coverage to help the public — and parents — in their understanding of the human side of child abuse and neglect.

Federal Standards

The present Act requires the Secretary with the assistance of the Advisory Board to develop Federal Standards. These Standards are not the basis for eligibility for federal funds but rather are suggested good practices, reflecting the best state-of-the-art knowledge and designed to help States, communities, public and private agencies, professionals, and private citizens to assess local program capabilities and to determine gaps in needed services.

A draft of these Standards has been widely distributed to State and local agencies as well as to individuals from professional disciplines actively involved in the field. The comments we received are overwhelmingly favorable and supportive of the concept and content of the Standards.

When the Standards are completed, we plan to develop a series of monographs and manuals for use in their implementation.

Assistance to States

Because State agencies play a key role in the direct delivery of services to families, the present law authorizes grants to the States to strengthen their prevention and treatment programs. To qualify for this assistance, a State must meet the list of criteria in Section 4(b)(1) of the Act. The scope and stringency of these criteria, which are concerned with effective reporting procedures, comprehensive definitions of child abuse and neglect, prompt investigation and court action on cases, confidentiality for families, immunity for those who report in good faith, court processes, cooperation among State and local agencies, and parental involvement, require most States to make significant changes in their legislative and administrative procedures. The two requirements which have presented the greatest difficulty for States are the comprehensive definition of child abuse and neglect and the required provision of a guardian ad litem in every judicial proceeding. Both of these generally require amendment of State law to achieve compliance.

Major progress has been made by States in upgrading their programs, as evidenced by the dramatic growth in the number of States which have become eligible each year. Only two States were eligible during the first year of funding. In Fiscal Year 1975, the number increased to 16. In Fiscal Year 1976, 29 States received grants. We project that over 40 States will be eligible for grants in the coming fiscal year.

Since the Act requires that our State grants must supplement and not supplant State funds already being expended on child abuse and neglect programs, they have been used primarily to develop innovative approaches in this field.

For example, several States have used these grants to focus public attention on the nature and extent of child abuse and neglect and the need to improve services. Other States have directed their attention to developing or improving their central register systems.

Emphasis has also been placed by several States on coordination and assessing the effectiveness of existing services.

Other States have sought to improve their overall system in other ways. Such as through creation of special diagnostic, psychological and health care for children and families where abuse and neglect is a factor and through broad ranged media campaigns. Vermont has prepared and distributed a pamphlet entitled: "HELP: ABUSED AND NEGLECTED CHILDREN IN VERMONT." Posters are also being displayed in a variety of places such as schools, stores, and public buildings; immediate spot announcements have been developed in cooperation with the State Broadcasters Association; and a number of interdisciplinary public forums on child abuse have been held.

To increase the number of eligible States, we are working closely with the remaining ineligible States. We conducted a detailed analysis of the factors preventing full eligibility and our Regional Offices are assisting the States to make the necessary changes. In addition to this direct assistance, a manual is currently being developed to provide guidance to States on how to improve their programs and thus become eligible for State grants.

Coordination Activities

In response to requirements of the Act, the Secretary created an Advisory Board on Child Abuse and Neglect. Reflecting the relevance of many areas of human services to the child abuse and neglect problem, the Board includes representatives from Justice, Labor, Interior, Agriculture, Housing, and Defense as well as HEW.

In addition to developing the Federal Standards, the Advisory Board is responsible for the effective coordination of Federal child abuse and neglect programs. The Board prepares annual reports on long-range plans and budget projections of Federal agencies; and on the results of past activities and contemplated future activities of Federal agencies in this field. It also reviews on an interim and continuing basis planned activities of Federal agencies.

Extension of the Act

We believe that we have made significant progress in coping with child abuse and neglect. The new Administration wants the opportunity to review the program along with other Federal programs. Therefore, we are proposing a one-year extension of the present Child Abuse Prevention and Treatment Act, so that our support of this program can continue while we examine the best means of achieving the goals of the program.

This completes my statement. I will be glad to answer any questions you may have.

# # # # #

QUESTION:	Would you summarize for the Subcommittee the Center's program plan for the next year or two?
ANSWER:	The draft Forward Plan for Fiscal Year 1978 calls for the following research and demonstration activities:

- Improved procedures which can be employed by child protective agencies and/or other community agencies and organizations to enhance their ability to handle self-referrals and promote the public's receptivity to self-referrals.
- Improved procedures for early identification and referral of troubled families in order to prevent child abuse and neglect.
- Effective implementation and utilization of the Federal Standards on Child Abuse and Neglect and the Model Child Protection Act to improve community and professional capabilities.
- Improved treatment approaches for such special program issues as child sexual abuse, adolescent abuse and neglect, and institutional abuse.
- Use of lay therapists in the delivery of services to abused and neglected children and their families.
- Improved collaboration between courts and child protective services and community mental health and child protective services.
- Treatment programs specifically targetted on dealing with abused and neglect children's emotional, social, and cognitive development.
- Statewide planning and coordinating structure.

In accordance with Departmental policy, the draft plan calls for each demonstration program to be evaluated.

The draft plan also details continuation of the State grants program, including provision of consultation, determination of eligibility based on legislation and administrative regulation, awarding and monitoring of State grants. The Center would continue the refinement of Federal Standards the performance of its Information Clearinghouse functions, the provision of technical assistance both directly and through publications geared for professional use, support for development of materials to be used in general public awareness and public education efforts, and support for the development and establishment of training capacities for relevant professionals and paraprofessionals. Finally, the Center's draft plan includes continuation of its already initiated projects to gather and analyze officially reported cases of child abuse and neglect and to gather and analyze incidence data in order to establish a baseline child abuse and neglect incidence rate.

QUESTION:	Does the law provide enough direction in terms of services?

ANSWER: Although P.L. 93-247 is basically addressed to the performance of research and demonstration activities, I would like to point out that the Center's programs do provide a very significant amount of services to children and families. For example, during the period July 1, 1975 to June 30, 1976 the Demonstration Treatment Centers and the Innovative Demonstration Centers provided services to 10,303 children and 5,837 families.

In addition, a number of States are using their State grants to provide services to children and families.

Hotlines

- Connecticut supports a "Care-Line" which handles approximately 750 telephone calls a year.
- Puerto Rico has just established a "hotline," for which figures are not yet available.
- Alabama opened its statewide "hotline," supported by its State grant, as of March 11, 1977.
- Arkansas has established a "hotline" which receives approximately 1,000 reports of self-referrals per year.

Emergency Services

- Maine is just beginning a comprehensive emergency services system.
- Massachusetts is just beginning a comprehensive emergency services system.
- Rhode Island is just beginning a comprehensive emergency services system.
- New Hampshire's new comprehensive emergency services system already has provided services to approximately 50 families.
- Illinois uses its grant to supplement a comprehensive emergency services system which serves approximately 18,000 children per year.

- Michigan uses its grant to supplement a comprehensive emergency service system which serves approximately 13,000 children per year.

- Minnesota uses its grant to supplement a comprehensive emergency service system which serves approximately 18,000 children per year.

Supplementation of Treatment Services

- Vermont has provided services for approximately 75 children in need of emergency services and/or medical consultations but who are not eligible for subsidized services through other funding sources.

- Louisiana has supplemented the support of Child Protection Centers, serving approximately 3,000 families per year.

- Oklahoma purchases medical consultations from the Children's Hospital in Oklahoma City, serving approximately 1,200 children per year.

- Utah purchases approximately 700 medical consultations per year for children not eligible for reimbursed services under other social services provisions.

- Tennessee supports in-home caretakers and homemaker services in homes where abuse and/or neglect have been identified. The current number being served is 138 families.

It is also important to note that the major source of funds to provide services is found in Title IV B and Title XX of the Social Security Act. How those funds are allocated and spent is a matter of State and local determination. On a comparative basis, the total resources available under P.L. 93-247 are limited. Should they be directed more toward the provision of services, the national effort to conduct essential research and demonstration would be impaired.

Therefore it would be desirable to continue a balanced effort similar to that which is currently the case.

QUESTION: Would you give us, for the record, a breakdown showing the amounts in both research and demonstrations?

ANSWER: Since the intial enactment of P.L. 93-247 the following sums, by fiscal year, have been spent on research and demonstration efforts:

FY	Research	Demonstration
1974	$ 107,000	$ 3,395,000
1975	2,169,000	8,762,000
1976 & TQA	2,136,000	11,863,000
Total	$4,412,000	$24,020,000

QUESTION: The Subcommittee is concerned about reports that suggest that the Center may have used its limited funds in such a way as to produce unnecessary duplication of efforts to some extent in this field. One example is its funding of a national media campaign to create public awareness of the problem of child abuse when at the same time a similar campaign is being conducted by a private organization, the National Committee to Prevent Child Abuse.

a. Do you know the costs of each of those campaigns?
b. Did you consult with the National Committee to Prevent Child Abuse before proceeding to obligate Federal funds?
c. Why do you need this particular effort?

ANSWER: From their inceptions, these separate public awareness programs have been coordinated. However, because the underlying purpose of each program differs so markedly from the other, it was not possible to develop a joint approach. The Ad Council/National Committee campaign is designed to raise public awareness of the problem of child abuse and of the existence of the National Committee. The National Center's public awareness program, on the other hand, was designed to provide assistance to State and local agencies which are ready to deliver a direct message to parents that if they need help in meeting their child care responsibilities, such help can be obtained through the agency indicated at the end of the public service announcement.

The National Center's decision to approach its public awareness responsibility in this manner was based on a number of factors, including:

- Child protective services are the responsibility of State and local agencies; it is inappropriate to raise public awareness of child maltreatment nationally with resulting increases in demands for local services and increases in self and third-party referrals without State and local planning and concurrence.

- Effective public awareness materials on child abuse and neglect must provide for immediate response systems; national referral centers can cause delays in responding to cases of child abuse or neglect which might be identified because of a media campaign.

The National Center developed a strategy for its public awareness technical assistance program in late 1974 and implemented it in January 1975 with the drafting of a request for proposals. A contract was signed in June 1975. The contractor undertook much more than the production of six television and five radio public service announcements. He also conducted a survey and review of all existing public awareness materials, consulted with a wide variety of public and private child welfare agencies across the country on appropriate public awareness messages, selected and provided technical assistance to twenty State and local social service agencies with child abuse and neglect programs in developing their own public awareness programs, and developed a manual on how to plan and carry out effective local public awareness programs on child abuse and neglect. The total cost of this contract was $477,414, extended over a period from June 30, 1975 to October 31, 1976.

Meanwhile, agreements to undertake the Ad Council/National Committee campaign were not formally announced until February 1976. In the Ad Council's early planning, the National Center and contractor staff provided assistance to the Ad Council by sharing the results of the national survey of existing public awareness materials as well as early drafts of the HEW scripts for television and radio announcements.

To date, the National Center's public awareness media materials are already being used by twenty State Social Service agencies, and the Armed Forces Radio and TV Services network is building them into its overseas military community programming. Ten more States are expected to use the materials in the coming two years. This activity will expand as State and local agencies determine their own readiness and capability to serve as sponsors of locally tailored campaigns. We do not know the cost of the Ad Council's campaign.

QUESTION:	A second example of duplication concerns the funding of the study to determine the incidence of child abuse and neglect and whether it is increasing. Can you tell the Committee how much money has gone to the American Humane Association and to private contractors for this purpose?
ANSWER:	The AHA grant is testing the feasibility of collecting statistics on officially reported cases of child neglect and abuse. In doing so, it works with State agencies to develop their own internal data management systems.

The Burt Incidence Feasibility Study performed an analysis of the methodologies available to perform an incidence study of child abuse and neglect. It laid the ground work for our understanding of how to approach a full scale incidence study.

The Westat contract was awarded to actually perform the incidence/prevelance study. The purpose of this study is to collect data on the "actual" number of abused and neglected children in this country. It thus seeks to determine the true number of cases whether or not they are officially reported.

	Grantee/Contractor		Period	Amount
Grant -	American Humane Assoc.		6/73 - 3/77	$606,000
Contract -	Burt Associates		2/75 - 11/75	$10[illegible]000
Contract -	Westat	Phase I	7/76 - 9/77	$511,000
		Phase II	10/77 - 9/78	$946,000

QUESTION: Can you give us a list of the job titles and salaries of personnel assigned the National Center on Child Abuse and Neglect?

ANSWER: The National Center on Child Abuse and Neglect presently has a total of 16 personnel assigned; 2 positions are vacant. Job descriptions for each of the positons are attached.

Position	Grade	Salary Range
Director	GS-15	$33,789-43,923
Special Assistant to Director	GS-14	28,725-37,437
Program Assistant	GS-9	14,097-18,327
Secretary to Director	GS-7	11,523-14,979
Chief, Program Policy & Planning Branch	GS-14	28,725-37,437
Social Science Analyst - 2	GS-13	24,308-31,598
Program Analyst - 2	GS-13	24,308-31,598
Program Analyst - 2	GS-12	20,442-26,571
Secretary	GS-6	10,370-13,484
Clerk	GS-5	9,303-12,093
Chief, Clearinghouse Branch	GS-14	28,725-37,437
Technical Information Specialist	GS-13	24,308-31,598
Technical Information Specialist	GS-9	14,097-18,327
Communications Assistant	GS-9	14,097-18,327
Secretary	GS-6	10,370-13,484

QUESTION:	How many people do you think are really needed to do the work of the National Center on Child Abuse and Neglect?
ANSWER:	When the Office of Child Development (OCD) initially developed implementation plans for P.L. 93-247 it estimated that 44 additional personnel would be required to perform central and regional office functions.

After review at several levels, the final request was for 35 additional positions to carry out the mandate of the Child Abuse and Neglect Prevention and Treatment Act of 1974. These positions were to be utilized to establish and operate the central office as well as to place specialists in each regional office. Today there are a total of 31 positions authorized, 18 in the central office and 13 in regional offices, of which 29 are actually filled.

Based on our experience of the past three years it appears that the initial analysis of personnel requirements made by OCD was valid.

QUESTION: Could you give us some idea of the work load for project officers managing your grants and projects? How many separate grants and contracts would each officer be monitoring and what is the approximate dollar value monitored by each project officer? Is this work load consistent with the general work load within the Department of HEW or is it a heavier load than elsewhere?

ANSWER: At the present time the Center is directly responsible for the project management of 66 grants and 9 contracts. Additionally, it funds 16 research projects for which it provides fiscal support and overview and is indirectly involved in the program monitoring of 10 grants and 23 contracts which have been awarded and managed through the regional offices.

There is wide variety in the demands and complexities of these grants and contracts, and one cannot assume that there is a direct relationship between the number and/or dollar value of projects assigned to a particular project officer and the work involved in their management. The following is a summary of the present work load within the Center, each group representing the assignment of a single individual.

Office of the Director

- Review State grant applications and provide technical assistance to States in order to satisfy eligibility requirements with budget allocation of $3,785,000.

Program Policy and Planning Branch

- Sixteen demonstration project grants with an annual budget of $4,140,000
- Nine demonstration project grants with an annual budget of $2,155,000; two contracts totaling $230,000; and, reviewing and monitoring the disbursement of $1.6 million of technical assistance funds to the regions.
- Twenty-eight demonstration project grants with an annual budget of $2,905,000
- Three contracts with an annual budget of $625,000 plus one grant with an annual budget of $300,00; responsibility for the processing and management of a new contract estimated at about $300,000.

- Six demonstration project grants with an annual budget of $1,050,000 plus responsibility for the processing and management of two new contracts estimated at about $800,000.

Because of work load requirements, two supervisory staff members are responsible, in addition to their supervisory responsibilities for:

- One contract for $241,000 plus one research project grant with an annual butget of $193,000.
- Four demonstration project grants with an annual budget of $785,000.

Clearinghouse Branch

- Three contracts totaling $2,840,000 plus one demonstration project grant with an annual budget of $200,000.

The Clearinghouse is now receiving approximately 1,000 pieces of correspondence per month, and the work involved in processing it calls for approximately 3 full-time person.

Other activities consume significant amounts of time of the project officers. Any correspondence which relates to a project must be answered by the assigned project officer. These same staff members must represent the Center at conferences, symposia, workshops, etc.

An analysis of the function performed by Center personnel reveal some unique characteristics - they embody policy formulation; interaction with representative of various Federal agencies, State officials, and representatives of private agencies; and the provision of technical assistance to organizations and individuals in both the public and private sector.

We have no way of comparing the Center's work load with the work load of other elements in the Department since we are unaware of any work load standards against which we may measure.

QUESTION: What has happened to the child abuse and neglect projects which were funded within the Department of Health, Education and Welfare prior to the enactment of P.L. 93-247?

ANSWER: In 1973 and 1974, the Department funded thirty-eight child abuse and neglect projects, including treatment demonstrations, research, curriculum development, parent self-help, state of knowledge, and survey projects. All but fourteen of these projects have been completed. Eleven treatment projects, an evaluation of these projects, and grants to Parents Anonymous and the American Humane are due to be completed in 1977.

These projects have contributed a number of important technical and research documents to the field of child abuse and neglect prevention and treatment. Among these are Planning and Implementing Child Abuse and Neglect Service Programs, Profile of Neglect: A Survey of the State of Knowledge of Child Neglect, Child Maltreatment in the United States: A Cry for Help and Organizational Response, Protective Services for Abused and Neglected Children and their Families, Focus: Child Abuse and Neglect (a multidisciplinary curriculum), Lift a Finger (A curriculum for Schools), and a standard reporting system for use by State agencies. (Copies of each of the above publications as well as a descriptive catalogue of each project, are available upon request.)

QUESTION: Would you give us a summary of what other Federal agencies are doing with respect to child abuse and neglect; what are they spending on these activities; and, what efforts are being made by you to stimulate programs and expenditures by other agencies?

ANSWER: Acting principally through the Federal Advisory Board on Child Abuse and Neglect, we work to encourage an increased level of cooperation and program coordination among the the member agencies. Information is shared and agencies are encouraged to utilize to the maximum extent feasible their existing programs, activities and/or service delivery mechanisms in order to more effectively identify, report, treat and prevent child abuse and neglect.

The following information was recently provided to the Federal Advisory Board on Child Abuse and Neglect by the some of the agencies represented on that Board. It describes the level of activity within each agency directed toward the prevention, identification, and treatment of child abuse and neglect:

Alcohol. Drug, and Mental Health Administration (ADAMHA)

The National Institute on Alcohol and Alcohol Abuse (NIAAA) and the National Institute on Drug Abuse (NIDA) do not have any programs that are primarily targeted for the prevention, identification and treatment of child abuse and neglect and do not fund any programs to train people who provide services to children who may be abused or neglected.

The National Institute on Drug Abuse has some treatment programs that have certain limited elements of service relevant to child abuse and neglect, such as counseling and other appropriate services when child abuse and neglect may be present. The National Institute on Mental Health reports that there are presently 649 community mental health centers,nineteen of which specifically mention child abuse and neglect in their project mission statements.

National Institute on Child Health and Human Development (NICHD)

Research and training projects supported by this Institute are relevant to child abuse and neglect in that they deal with the problem before a child is abused or neglected and are primarily concerned with such important issues as maternal-infant interaction, attachment behavior, and the nature of the bond between parent and child.

In FY'76, NICHD spent $1,788,570 in support of projects that are relevant to child abuse and neglect. During the transition period, $344,567 was obligated. It is anticipated that $1,939,000 will be spent on child abuse and neglect activities in FY '77 based on FY'76 obligations.

Public Health Services

The Health Services Administration of PHS currently funds three programs relating to child abuse and neglect: (1) a study is underway to determine if the infant's contribution to a reciprocal interaction which a mother perceives is necessary in the formation of mother to infant attachment; (2) the effects of two kinds of intervention programs on the development of premature infants and the caretaking behavior of their parents; and (3) a study to develop a battery of tests with which to identify parents who have potential for abuse and/or neglect of their children, These projects are supported at the approximately level of $577,925.

PHS has funded for the past three years an evaluation of the eleven jointly funded SRS-OCD child abuse and demonstration projects at a total cost of $875,000. ($515,000 in FY 1976)

Public Services Administration

The Public Services Administration, when still a part of SRS funded three grants in the amount of $857,000 for projects with a primary focus on child abuse and neglect. These programs are funded to (1) train central and regional office staff of OCD and PSA in the use of the Guide on Protective Services for abused and neglected children; (2) develop a manual on the legal aspects of protective services to abused and neglected children to be used in the training of workers in local welfare departments and (3) a research study to discover the early warning signals of serious abuse and neglect of children.

Additionally, SRS made $200,000 available from FY '76 funds to assist OCD in the final funding of the eleven jointly funded demonstration treatment centers.

Two major sources of Federal monies to assist states in the provision of protective services to children and families are:

(1) Title IV B of the Social Security Act, with the goal to prevent, remedy, or assist in the solution of problems which may result in the neglect, abuse or exploitation of children had a total of $752,558,000 available in Fiscal Year 1976 -- the Federal share is $52,500,000 and the States share is $700,058,000. Of this amount approximately $46,455,000 was spent on child Protective Services ($3,239,000 federal share, $43,216,000 state share). (2) Title XX of that Act has as one of its five goals to prevent, or remedy neglect, abuse or exploitation of children unable to protect their own interests or preserve, rehabilitate or reunite families. A total of $168,00,00 of Federal funds was spent for services to abused and neglected children and families out of the total FY '77 appropriation for Title XX of $2.376 billions.

Department of Labor (DOL)

The Department of Labor has allocated $4 million to several programs which they report, have a partial focus on child abuse and neglect. Some programs funded seek to determine if work experience, combined with peer group reinforcement, will lead to reduced school dropout rates after age 16 and improved labor market experience for the students upon leaving school. Another project provides for a longitudinal study of the educational and labor market experience of youth.

QUESTION:	Do you know what percentage of funds spent under this Act have been awarded to profit-making consulting firms and what percentage non-profit entities?
ANSWER.	During Fiscal Years 1974, 1975, 1976 and the Transition Quarter, the National Center on Child Abuse and Neglect obligated $39,593,000. During that period of time contracts were awarded to profit-making firms totaling $6,210,000. Thus the percentage of all funds spent on contracts awarded to profit making concerns averaged a little over 15%. Examined on an annual basis the figures show a consistent downward trend. The percentage for FY 1974 was approximately 23%; in FY 1975 it dropped to 16%; and, for FY 1976 and the Transition Quarter it was 13%. Aside from approximately 1% spent on publication and printing costs, and administrative costs related to processing contract/grant announcements, the remaining 84% of the Center's total funds have gone to non-profit private grantee organizations or agencies of State and local government.

QUESTION: How do you evaluate programs funded under the Act and what conclusions have you drawn from these evaluations?

ANWER: Every demonstration grant is evaluated by an outside contractor. In the early history of the National Center on Child Abuse and Neglect it was decided that the projects would initially be evaluated from formative or process perspective -- in other words we would want to know what it was that the projects had done; how they had organized themselves; how they had gone about identifying community needs, and community resources; what problems they had encountered and how had they resolved those problems.

In order to evaluate the three different categories of demonstrations being funded, three formative evaluation contracts were awarded. Each of those contractors has worked closely with the particular projects for which it was responsible not only from the stand point of gathering data but for the purpose of providing technical assistance of a management nature to the projects as well.

All three of these formative evaluations are now in their concluding phase. Within the next two months contractors will have concluded their last site visits to the projects and will be developing their final reports which will be of value to indi-vididuals and agencies at the local and State level who must plan, implement and operate programs to prevent, identify and treat child abuse and neglect.

The Center plans to initiate later in the year a summative or impact evaluation of these projects. The purpose of this evaluation will be to get answers to questions related to the impact made by the demonstr tion treatment projects. Having learned from the forma tive evaluation how projects had approached the organizational and functional problems inherent in their operations, the summative evaluation will tell us what happened to the people and the communities where those projects operated.

The results of the summative evaluation will follow the termination of the demonstration treatment efforts in 1978. Thus it is too early to draw any final conclusions from these demonstration efforts; however, one theme that is appearing in all projects is that the quality of services to children and families within a particular community are directly related to level of cooperation and coordination achieved between the serving professions and agencies within that community.

The evaluation of the 11 demonstration treatment projects jointly funded by the Office of Child Development and the Social Rehabilitation Service is now at the state of beginning to draft its final report. Preliminary data will be available later this year.

Senator **Cranston**. We now have a panel to testify consisting of Mr. Steven Bricker of the American Civil Liberties Union Juvenile Rights Project in Richmond, Va., Mr. Brian Fraser, National Committee for the Prevention of Child Abuse from Chicago and Ms. Vanette Graham, National Association of Social Workers, Washington, D.C.

We would appreciate it if you would submit your full prepared statements, if you have them, for the record and rather briefly summarize the outstanding key points to us so that we have time for some questions.

STATEMENT OF STEPHEN W. BRICKER, STAFF ATTORNEY, JUVENILE RIGHTS PROJECT, AMERICAN CIVIL LIBERTIES UNION, RICHMOND, VA.; BRIAN FRASER, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE, CHICAGO, ILL.; AND VANETTE GRAHAM, NATIONAL ASSOCIATION OF SOCIAL WORKERS, WASHINGTON, D.C., ACCOMPANIED BY LEILA WHITING, PROJECT DIRECTOR, CHILD ABUSE AND NEGLECT TRAINING PROJECT, A PANEL

Mr. **Bricker**. Senators Cranston and Hayakawa, my name is Steve Bricker. I am with the American Civil Liberties Union.

The ACLU has had considerable interest in the legal rights of the Nation's youth for a good period. The historic In re *Gault* case was handled by the ACLU, and in more recent times we have established the juvenile rights project to handle litigation in this area.

Approximately a third of the present 150 cases on our docket deal with varying aspects of the protective services system, including foster care. I am here to criticize the act and to criticize it fairly severely. I should put one caveat on that; the act in some senses is fairly neutral and some of my criticism will be directed more toward the administration of the act by OCD rather than the language in the act itself.

During yesterday's hearing Dr. Zigler from Yale was asked his opinion on the proposals made by Dr. Kemp and others as to whether or not there should be periodic screening of all children for child abuse potential and the concept of health visitors. In his response, Dr. Zigler said that that possibility would raise a civil liberties monster. I think monster is the word he used.

I think we have already got it in many ways. I will give my recommendation first and attempt to document it. I would recommend that the act be severely amended so as to remove any authority to promote coercive intervention systems in family life dealing with neglect rather than abusive forms of assault upon children; that is, physical or sexual assaults.

Senator **Cranston**. Would you restate the recommendation? Just say what you said again.

Mr. **Bricker**. My recommendation is the act be limited—limit OCD's authority to promote coercive intervention systems only to child abuse, that is, physical or sexual assaults, and that all programs or activities dealing with so-called emotional abuse, so-called neglect, be transferred to other agencies or other programs where client participation is voluntary.

I will now proceed to my criticism. The first question is what are we dealing with. The principal characteristic of the act, at least as administered by OCD, is the promotion of coercive intervention systems. As set forth in their model State legislation, the system begins with the creation of a mandatory reporting law which requires various professionals, under penalty of criminal prosecution, to report to welfare authorities all suspected—and I emphasize suspected—cases of abuse or neglect.

The system functions largely without regard to voluntariness either on the part of the child or the parent. That is, the system is not set up to deal with the request of the children or the parent but what someone else thinks should be done.

I think, factually, one thing you should keep in mind is that even though this act is labeled a child abuse act, functionally, in the field, as it operates, it is a child neglect act. The vast majority of the cases that are dealt with by the responsible agencies are not abuse but neglect, the vast majority.

In Virginia, for example, which was one of the first States to enact an OCD approved child abuse law, during the last reporting year less than 1 in 10 of the confirmed cases dealt with an actual physical or sexual assault upon a child. Again, the vast majority were these things which we call neglect and emotional abuse, whatever they are.

Second, the question is: Who are the clients that receive these services? With only occasional exceptions, they are all poor. In many ways, the act could be dubbed "war on poverty of the 1970's." We are dealing with the poor population of this Nation.

Having dismantled the Office of Economic Opportunity, having abandoned any real movement to provide an adequate income for our Nation we now require poor people to obtain services to protect their children rather than provide such on a voluntary basis.

It is the current gospel among many professionals active in the child abuse area that child abuse is a common phenomenon throughout all economic segments. So far as the system actually operates, that statement is a lie. It may be true so far as abuse goes that there may be abuse in all segments, but that is not the population subject to the act.

I have been active in this area for a number of years and almost without exception every case I see is a poor family. The parents who testified before this committee yesterday were from poor families. Every major study on the subject of child neglect has found a direct correlation between neglect and poverty, so we are dealing with poor people.

Senator CRANSTON. Is this true in abuse as well as neglect?

Mr. BRICKER. It's probably not as a direct correlation. There are two different questions here; one is, who does the system deal with; and the other question is in what families does this occur because the system doesn't necessarily deal with everyone?

I think, as to child abuse, the system deals almost entirely with poor people. There may be other economic segments of the community who abuse their children, but again, the research is at such a preliminary stage we really just don't know.

Then the question is what do the families who are the subject of these inquiries get out of the system? I think there is a reason—not a very good reason—there is a reason why the coercive model was adopted, and that is that we view abusing parents as bad.

I am sure the members of the committee and those in the audience have seen pictures of abused children and it is a very shocking kind of experience to have to directly encounter that, and so your logical analysis is, who would do that to a child. It has to be someone who is sick, who is pathalogical.

But again, remember the vast majority of the clients coming in to the protective service system have not done that. It is some lesser form of family disfunction. I would submit that what we call neglect is not a parental response but a societal response to the crippling effects of poverty which have existed in this country for a long period of time and which continue to exist.

I think also, Dr. Zigler in his testimony yesterday, at least in his prepared statement, emphasized that what we are dealing with is an ecological intervention; that is, we have a society which produces certain kinds of parental responses, certain kinds of family stresses and until we make a societal response to the problem we are not going to provide real services to the families and children in trouble.

I think also it is important to remember that there is no money under the act, virtually no money under the act which finds its way to the States which actually go to the provision of services. The vast majority of the money—and remember again, it's only 20 percent of the appropriations that are going to the States—but the vast majority of that 20 percent goes into setting up reporting systems.

Again, Virginia may serve as a good example. The State, in 1975, passed its OCD-approved child abuse law. The State legislature in its wisdom appropriated the total of $40,000 to implement the legislation. Virtually every cent of that money went into setting up a central registry, went into setting up a central office to process the reporting system.

The act did put additional responsibilities on the line case workers who had the responsibility for this system. What that did is divert case workers from hard line services to families into investigatory functions so that social workers who were previously in the business of providing social services to families found themselves spending a proportionately greater amount of their time out in the field investigating, finding out if there was abuse or neglect.

The net effect of the Virginia legislation was to actually decrease the amount of services available to families.

I think functionally what you are dealing with is you say we've got a problem and you say we want to provide services, but what you get is a social worker at your door and it is at the door of a poor family which is feeling a number of different stresses which are felt by all poor families.

The provision of a social worker for every poor family in the Nation is not going to deal with the problems which create child neglect. We have known long before the phenomenon of child abuse made the front pages that poverty had a crippling effect upon children.

The incidence of infectious diseases and incidence of low birth weight is substantially greater among children who are poor. Sixty percent of all mentally retarded children in this Nation are from poor families. We know that poverty hurts children.

What we should do is we should look for voluntary services to deal with these problems. If poverty causes child neglect we should have an income maintenance program. If adequate health services is the problem, and I think to an extent it is, we should have adequate health care for the poor and poor children.

Having made I guess what is an overly serious summary, and it may have gone beyond a summary, I'll conclude with a story I heard down in Richmond. The story is basically just three questions which are supposedly the most suspicious statements anyone can ask.

The first is: The check's in the mail; The second is: Of course I'll respect you in the morning; and the third is: I'm from the Government and I'm here to help you.

Senator CRANSTON. Thank you very much. I would like to ask you one question. Is it true there is nothing in this act that coerces parents to receive services under the act? There are State laws against abuse and neglect and what this act seems to do is provide research and development of services to families that need help because of these problems. Coercion comes from somewhere else, not from this act.

Mr. BRICKER. That's largely true except for the fact that child neglect is included within the definition of the area of inquiry. My essential point as to child neglect is it is not something that needs particular attention. It is part of the broader problem; that is, poverty in this Nation. The principal problem is the administration.

OCD has developed the Model State Act and no State can receive funds unless they have all the items in that act in their local law. That model act requires a mandatory reporting system for child neglect. There was a recommendation made to OCD about 1½ or 2 years ago that that be eliminated.

I think a member of this committee criticized that, but that was not adopted.

Senator CRANSTON. Senator Hayakawa?

Senator HAYAKAWA. Yes, please.

Did I understand you to say, Mr. Bricker, that what we call neglect is not nearly so much parental as it is societal, that these are the crippling effects of poverty? What would you say, Mr. Bricker, to an assertion that I have heard made and I wanted to make myself, that there are an enormous number of cases of child neglect in families of the affluent?

They buy their children sports cars, liquor or whatever is necessary, and then go off to Europe, and they get into trouble constantly except that because they are affluent they do not get the attention of social agencies. Only occasionally do they come to the attention of police, but there is enormous neglect that cuts across all social classes.

And, insofar as child abuse is concerned, we heard testimony here just the other day to the effect that many cases of child abuse among the affluent do not come to police attention because they are disguised as accidents, and so long as the parents are poor we say poor people abuse their children, but when they are rich we say sometimes they have accidents and they are wealthy enough and influential enough in the community to get away with calling them accidents.

I would like your comment on this. It seems to me neglect happens regardless of social class and sometimes poverty may increase it as a result of the pressures you described, but neglect is endemic through all social classes and so is abuse. These are failings of individual human beings not societal conditions, so far as I can see.

Mr. BRICKER. I guess there are essentially two questions; one is to neglect and one is to abuse. The one dealing with neglect—obviously, my statements here today are a generalization. When I say neglect is a poverty problem I am speaking of it in the sense of what the governmental response should be.

It is true, many affluent parents neglect their children. They send them away to boarding schools and things like that, summer camps, so they never have to deal with them. The question is, is that why you and I might agree that that is neglect——

Senator HAYAKAWA. Yes; I think it is the reason why you and I might be concerned about this, because there are enormous behavior problems among the children of the affluent. They are trouble in communities. I know of very, very high class communities in California where the adolescent, the growing young man and woman is a constant problem to the community. It is not their lack of money that is the problem, it is the fact they have too much. They are a problem. This is not a poverty program strictly speaking. We are not concerned with poverty. We are concerned with children and their proper care and upbringing.

Mr. BRICKER. That is the central issue and the question is what governmental response is appropriate to deal with that problem. Here I'll raise a conservative flag; it is a question of what good does result from a coercive system like what we are dealing with.

Senator HAYAKAWA. One of the dangers of your approach is there are certain cliche ways of thinking about the poor, as if they were a different class of people from the affluent. The poor have moral character. What they lack is money, but the poor are capable of sacrifice on behalf of their children, the poor are capable of disciplining their children, the poor are capable of bringing up children in log cabins to become President of the United States.

Poverty is not the cause, the main cause of people problems. Another thing you said which really bothered me is that 60 percent of all mentally retarded children are from poor families. This simply is not the case unless you accept the social definition of mental retardation. Mental retardation is a genetic defect. It is a birth defect. It also goes through classes again. What do you mean, 60 percent of all mentally retarded are from poor families?

Mr. BRICKER. That is a Government statistic.

Senator HAYAKAWA. Where did they get it?

Mr. BRICKER. I could find out for you if you are interested.

Senator HAYAKAWA. Because this simply is not the case unless you say everybody who has a poor academic record is mentally retarded. That is certainly a social definition, not any scientific definition.

Mr. BRICKER. I am relying on Government statistics. The important thing in dealing——

Senator HAYAKAWA. The fact that you relied on Government statistics when mental retardation is so well known means you have this thing about poverty as a very specially crippling condition, which, however, the majority of humankind have always suffered from and many people have endured it very, very well, and it has improved their character.

Mr. BRICKER. Since you raised the subject of retardation, which I think is probably a good demonstration of some of the points I am dealing with, I would like to deal with that.

You made the statement that retardation, or the incidence of retardation is not related to social conditions but is a result of genetic factors. Like child abuse, research into retardation is at a very early level but there are significant indications that the statement you made is not true, that nutrition, both as to the pregnant mother and as to the child, shortly thereafter has a very significant impact.

Early intervention techniques—that is, a child who is born with a retardation possibility, the medical, educational, and social services that child receives after birth have a very dramatic impact upon whether or not that child will, in fact, grow up to be a retarded individual.

Low birth weight is extremely common among poor babies. Low birth weight has been directly connected to the later incidence of retardation. So, all these kinds of social factors can have a very significant impact on the intellectual capacity of a child and all those factors that go into that are directly connected, not across the board, but as a statistical matter, are connected to poverty.

I think the same thing is true of neglect. We know that low birth weight creates a lot of retarded children who would not be retarded had they had a full gestation period, had they been born at normal weight.

Senator CRANSTON. In effect, then, diet has a lot to do with it?

Mr. BRICKER. Diet or prenatal care, general health condition of the mother, supposedly emotional stress can cause premature birth, a lot of these types of factors. Obviously, retardation hurts children. What are we doing about it? Health care for poor people in this country hasn't improved and, if anything, it is getting worse as the health care costs go up. That has a direct effect on the development of children.

Senator HAYAKAWA. Is it really true that health care for the poor has not improved despite the billions and billions we are spending on it?

Mr. BRICKER. In recent years it has not as the cost has gone up.

Senator HAYAKAWA. Actually, there are very few people who suffer from actual hunger. They may suffer from the wrong nutrition. They eat the wrong foods, but actual cases of starvation in this society are not like those of, say, India, where you really have a lack of anything to eat. The kind of birth defects you are talking about do happen in India but they do not happen in this country simply as a result of malnutrition.

Mr. BRICKER. Senator, I would love to have you come down to the south side of Virginia where malnutrition is extremely widespread. In Virginia you have ADC levels—I don't know what the exact level is—60 percent. The income maintenance level is 60 percent of the 1970 level necessary to support a family.

Let's say the cost of living has increased 10 or 20 percent since 1970. That probably means the family is getting 40 to 50 percent of the financial resources they need to sustain themselves. So what do they buy? They don't buy vegetables. They don't buy meat. They buy grains.

Senator HAYAKAWA. Urban families, or rural?

Mr. BRICKER. Urban and rural. There is also a very high incidence of retardation throughout the South, principally because it is a traditionally poor area and factors such as malnutrition enter into the picture.

Senator HAYAKAWA. Mr. Chairman, I submit the gentleman is talking about cultural deprivation and not retardation.

That is all. Thank you very much.

[The prepared statement of Mr. Bricker follows:]

TESTIMONY ON THE
CHILD ABUSE PREVENTION AND TREATMENT ACT
(P. L. 93-247)
BEFORE THE
SENATE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT

BY

STEPHEN W. BRICKER, STAFF ATTORNEY
JUVENILE RIGHTS PROJECT
AMERICAN CIVIL LIBERTIES UNION
April 7, 1977

I am happy to have this opportunity to discuss the Child Abuse Prevention and Treatment Act with the Subcommittee. Before I deal with the Act, I should provide some background on the American Civil Liberties Union and myself. The ACLU is a membership organization, composed of over 275,000 members, dedicated to the defense of the Bill of Rights. During its fifty-six years, the ACLU has devoted considerable effort to protecting the rights of children, particularly when these are threatened by arbitrary invasion by the State. The historic case of In re Gault, which established the contemporary basis for protection of juveniles' constitutional rights, was handled by the ACLU. In more recent times, the Union has established the Juvenile Rights Project to develop and coordinate litigation designed to protect the legal rights of the Nation's youth. Over 150 ACLU cases in this area are now pending or have been recently decided. Over 50 of these cases deal with varying aspects of the child protective system.

I have been employed as an attorney with the Juvenile Rights Project for over two years, concentrating my efforts in Virginia and other Southern states. During this time, I have personally represented innumerable juveniles and other family members involved in the protective service system, in individual cases as well as class action suits broadly affecting institutional practices or policies. In addition, I have worked closely with state administrators and legislators attempting to reform the juvenile system. For example, for almost two years, I served as a consultant to committees of the Virginia legislature which drafted a new juvenile code. A major component of this new Virginia legislation, which was signed into law by Governor Mills Godwin last Thursday, is protective services and foster care. Thus, my experience allows me a dual perspective, both as a child advocate seeking reform from outside the system, and as one dealing with the practical financial and administrative problems faced by those responsible for the system's operation.

From this experience and perspective, I have come to the Subcommittee to offer rather harsh criticism of the Act and its administration by the Office of Child Development. My essential point is that the protective service systems promoted by OCD do not help the bulk of the children being "served" and are often harmful. In addition, there is an overwhelming class bias in the actual operation of these systems, to the extent that P.L.93-247 might be dubbed the "War on Poverty of the 1970's." Because of these problems, I would ideally recommend that the Act be substantially amended so as to restrict involuntary intervention systems to only the most severely endangered children and that all other functions now performed by OCD under the Act be transferred to other programs where client participation is voluntary. Recognizing, however, that this recommendation would take a good deal of time to implement and that it may not be among those options being given close study by the Subcommittee, I do endorse the Administration's request for a single-year extension of the Act in the hope that my more sweeping suggestion will be given detailed consideration next year.

I will now attempt to document my criticism. The place to begin is with the Act itself, as administered by OCD. The dominant characteristic is the promotion of involuntary and coercive protective service systems among the states. As set forth in OCD's model state legislation, this system begins with the creation of a mandatory reporting law which requires a wide variety of professionals to report, under penalty of criminal sanction, all "suspected" cases of child abuse or neglect to public welfare officials. Within a short period of time welfare workers must investigate each case reported. If abuse or neglect is thought by the caseworker to be confirmed, "appropriate" services are to be offered to remedy the problem. If these are rejected or ineffective, judicially-enforced intervention is available, which often takes the form of removing the child from the home and his or her placement in foster care.

While both parents and children can themselves initiate this process, voluntariness plays a largely insignificant role, both as a matter of theory and actual operation. At the intake stage and thereafter clients are overwhelmingly brought into the system without regard to choice. The reason for this coersive structure is perhaps obvious: we view abusing and neglectful parents as "bad" and do not trust them to initiate corrective action. What may not be so obvious is the faulty theoretical basis upon which this assumption rests. Public and professional interest in child abuse is a very recent phenomenon, beginning only in the early 1960's. Virtually all of the initial research and literature was developed by physicians, psychologists and members of allied professions. This arose principally from clinical experinece and contact with abused children, many of whom had been severely assaulted. From this perspective, the "psychopathological" view of child abuse arose and was universally accepted up until only the last few years. Using the medical emphasis upon sickness as the principal focus, early researchers concluded that child abuse was the result of the psychological weaknesses or abnormalties of abusing parents. See Steele, B. and Pollack, C., "A Psychiatric Study of Parents who Abuse Infants and Small Children", in the Battered Child, R. Helfer and C. Kemp, eds. (1968). While this model may have been valid when severely abused children are considered, its application to the much broader forms of family disfunction covered by the Act is unwarranted. Gelles, R., "Child Abuse as Psychopathology: A Sociological Critique and Reformulation", 43 Amer. J. Orthopsychiat. 3 (1973).

But this is exactly what the Act does. At least as administered by OCD, it casts an amazingly broad net, including such categories as emotional abuse, neglect and threatened abuse. In response, many of the states have even expanded the areas of coersive government intervention. In Virginia, for example, which operates an OCD-approved system and which relies heavily upon OCD policies and model regulations, the state Department of Welfare has included the following within its definition of abuse/neglect:

-"Emotional abuse due to his/her environment"

-"Denied normal experience that produce [sic] feelings of being loved, wanted, secure and worthy"

-"Emotional neglect"

-"Exposed to unwholesome and demoralizing circumstances"

-"Listless/tired with no apparent reason"

-"Moral neglect".

Virginia Department of Welfare, Social Services Manual, Section 6500. Moreover, the large majority of cases reported deal with these less defined and less severe forms of family dysfunction, rather than severe physical abuse. To use Virginia as an example again, during the 1975-1976 one-year reporting period only 375 of the 4,703 confirmed cases of child abuse/neglect involved physical or sexual assaults. Virginia Department of Welfare, Bureau of Protective Services, Annual Report, 1975-1976. This is only 8 percent of the total confirmed cases! If Virginia's experience is representative of the Nation as a whole, our child abuse programs deal principally with these lesser forms of family dysfunction.

And there is almost no evidence that these forms of child abuse/neglect result from parental pathology or that a coersive intervention system is therefore necessary to deal with them. On the contrary, I would suggest that the roots of simple neglect lie not with parents but with our societal failure to provide an adequate life for poor children and families. While it is the current gospel among those who promote coersive protective service systems that child abuse is common among all social classes, the actual operation of these systems demonstrates that poor families are almost the sole recipients of child abuse "services". Every major study dealing with this subject has found a direct correlation between neglect and poverty. Katz, S., When Parents Fail (1971), pp. 24-25. My personal experience has been similar: almost without exception, state intervention on "behalf" of neglected children involves poor families.

This phenomenon should not be surprising. First, we were out to get poor families in the first place. The parental and family characteristics promoted by OCD and others as being indicative of child abuse/neglect are almost identical to the demographics found among the poor. Compare, Steele, B. and Pollock, C., supra, dealing with child abuse, with Pavenstedt, E. (ed.), The Drifters: Children of Disorganized Lower-Class Families (1967), dealing with poverty. The harsh realities of this correlation were recently brought home in a study which compared 17 abused children with a like number of demographically matched children who had been injured accidentally. Elmer, E., "A Follow-up Study of Traumatized Children", 59 Pediatrics 273 (1977). Both sets of children were also paired with demographically matched children who had been neither abused nor accidentally injured. All children were studied intensively for physical and emotional health and educational and social achievement at the time of initial referral and eight years thereafter. The bulk of all the children were lower class, since the abused children were poor and the two other groups had been paired with them. The finding was that there were almost no group differences between the abused children and either the accident victims or the untraumatized group. However, all three groups shared a wide variety of problems. Fifty percent evidenced emotional disturbance, seventy percent had speech difficulties and approximately 40 percent had severe school difficulties. In addition, the author found that "the children had an air of depression, sadness, and anxiety." She had expected to find that child abuse led thereafter to emotional problems, health disorders and language difficiencies. Instead, Elmer concluded that poverty itself may be as damaging to children as abuse.

Second, we have known for a long time that poverty has a crippling effect upon children. For example, we know that:

- -three-quarters of the 1.7 million mentally retarded children in the country are poor.
- -over twice as many children born into poor families have low birth weights, which means that they are three times as likely to suffer physical and mental handicaps.
- -the incidence of TB, influenza, polio, whooping cough and pneumonia is directly connected to family income: the lower the income, the higher the incidence.
- -the dropout rate for poor children is more than twice as high as that for middle class youth.
- -sixty percent of all arrests for delinquent behavior are of juveniles from poor families.

In addition, numerous studies have documented the fact that children from poor families are much less likely to achieve normal intellectual growth and other types of development. See, e.g., Bronfenbrenner, "Is Early Intervention Effective", in A Report On Longitundinal Evaluations of Preschool Programs (HEW Monograph No. 75-25, 1974); Wedge, V. & Prosser, H., Born to Fail (1973).

But what do poor children gain from child abuse services? The answer is very little. The great bulk of the federal money going into the states' programs goes not to actual services but to the operation of reporting systems. The states too have failed to provide hard services. In Virginia, the state enacted its OCD-approved child abuse law in 1975. The legislature appropriated only $40,000 to implement the law, virtually all of which has gone into establishing a central registry and other reporting functions. The new law did place added responsibility upon local welfare departments, principally in the area of investigating the reported cases of abuse/neglect. But since no additional money accompanied this responsibility, the net effect was to actually decrease the amount of services available to families, since casework services had to be diverted to investigate duties.

Moreover, there is a substantial question as whether existing child abuse programs would be effective, even if adequately funded. The coersive protective services model employed by OCD is virtually untested. There is simply no evidence that it helps children or families. On the contrary, there are indications that it does the reverse. The only universally available service is foster care, and increasing evidence has demonstrated that it is damaging to children. See, GAO Report, "Children in Foster Care Institutions – Steps Government Can Take to Improve Their Care," JRD-77-40, Feb. 22, 1977; Mnookin, R., "Foster Care – In Whose Best Interest?", 43 Harv. Ed. Rev. 599 (1973); Goldstein, J., Freud, A., and Solnit, A., Beyond the Best Interests of the Child (1973). According to the recent study performed by Elmer, supra, the abused children who were placed in foster care were worse off eight years later than their counterparts who were allowed to remain in their own homes. Less intrusive services, ranging from day care to traditional casework, have also proved largely ineffective. According to one noted commentator:

> "Despite approximately 70 years of experience, there is remarkably little evidence demonstrating the effectiveness of social work intervention...While there are numerous claims of success in individual cases, the little existing hard data tend to indicate that providing such services, at least to unwilling clients, is not very helpful." Ward, M., "State Intervention on Behalf of 'Neglected' Children: A Search for Realistic Standards," 27 Stanford L. Rev. 985, 997-998 (1975).

Given the limited returns obtained from the coersive model, there is no justification for its continuation, other than for those children who are severely abused or endangered.

The net effect has been to strike an unfair blow upon the family life of the poor. Like the AFDC man-in-the-house rule, this Act can only lead to a further deterioration of family stability among the poor. If we are truly concerned about neglected children and the crippling effects of poverty, let us take action in a form which promotes family life, not one which abuses it.

Senator **Cranston**. Mr. Fraser, do you want to proceed?

Mr. **Fraser**. Mr. Chairman and Senator, my name is Brian Fraser. I am the executive director of the National Committee for the Prevention of Child Abuse in Chicago. Before I assumed that job I worked with C. Henry Kempe in Denver at the National Center for the Prevention and Treatment of Child Abuse and Neglect.

While I was there one of my responsibilities was to direct one of the regional resource projects funded through this act. I am not known as an apologist for OCD. I think I should say, however, that I think what my colleague was talking about were the requirements that are found in this bill in section 4(b)(2). There are 10 conditions precedent that the State must meet before it is eligible to receive Federal funding. It is not a question of a model law developed by OCD.

It has now been over 2 years since the Federal Government enacted into law the Child Abuse Prevention and Treatment Act and I would be remiss if I didn't concur with my colleague, Dr. Kempe and say that the passage has had a number of positive effects.

Today there is increased public awareness about the problem. Today there is a Federal focal point for child abuse programs. Today there is an encouragement of some new endeavors and now excellent programs have been funded.

I would be equally remiss, however, if I was not just as honest with you and said there are some problems that do need to be addressed. I think it would be fair to characterize the problem of child abuse in three rather short phrases.

The problem is monumental in proportion. The costs are staggering and available resources are limited. We debated rather vigorously about how to present our testimony to you this morning and at the risk of being overly simplistic we decided to be simplistic.

One of the reasons we decided to be simplistic, I guess, is we lack the sophistication and the ability to be somewhat pithy that people on the east coast do. The national committee is the organization that is currently fostering and promoting a public awareness campaign. We have been working with the Advertising Council of New York for the past 17 months now.

The actual mechanicals were developed by the Campbell Ewall Co. in Detroit. Those are the folks who developed the Chevrolet spots. The mechanicals are finished, sent to New York. The Advertising Council duplicates them and distributes them throughout the country.

We send those spots to every television station in the country, every radio station in the country, every major newspaper in the country, the majority of the billboard companies around the country and the majority of public transportation companies around the country.

We were informed approximately 11 months ago that the National Center here in Washington, D.C. also had a public awareness campaign. We attempted a number of times to get together and coordinate our activities. We met in New York; we met in Washington. We simply, for some reason, were not able to coordinate those activities. We very much would appreciate a copy of Mr. Rosoff's written explanation of why that hasn't happened.

I am basically going to talk about the problems, and it is sort of a simplistic approach. One: Today there is a lack of direction and a lack of goals on the Federal level. The stated purpose of the law, the Mondale bill, Public Law 93–247, is the identification, the treatment, and prevention of child abuse and we believe today it might be somewhat prudent to be somewhat more specific.

Federal funds are now utilized to support demonstration projects, various research projects, and resource projects with the assumption that these projects are going to define their objectives and those objectives are going to evolve into the one national program or one national policy and that just hasn't happened. It would be rather naive to assume that it is going to happen in the future.

We believe that it might now be prudent for the Federal Government to tell us what they have done over the past 3 years, what they expect to accomplish or what they would like to do over the next 12 months. We simply point out with our due respect that once somebody does define reasonable goals and reasonable objectives it is possible to develop at least in general terms a national plan or blueprint for a Federal effort.

Once you have a plan or blueprint it makes it possible to delineate and evaluate current and future programs. It also makes it possible to identify and focus on future priorities. It also makes it possible to evaluate the National Center's program in Washington, D.C., something we are not currently able to do.

What we are trying to say in very simple terms is that it is now time to go somewhere but until you know where you are and unless you know where you want to go it is very difficult to get there. I am no different from anybody else. I like to get in the car on Sunday and wander aimlessly around the countryside, but when you're driving around distributing $65 million I think you have to sit back and question your motives and the allocation of funds.

Two: There is a duplication of efforts in the country today. Again, at the risk of being overly simplistic, we would suggest that there is a duplication, a tremendous duplication. But perhaps that's not startling when you remember that we don't really have any goals or objectives and it is goals and objectives that give you a frame of reference to work in.

Duplication and fragmentation exist at all levels: communities, the States, the regions, and on the Federal level. I am not too sure, but perhaps that's one of those things we have to learn to live with. But it does seem to me it's a problem we should be addressing and perhaps if we did have some policies, some goals, some objectives, perhaps we could all be aiming at the same thing. We wouldn't be doing away with fragmentation and duplication but we sure wouldn't be making the problem any worse.

We would suggest that perhaps one of the most important roles that the Federal Government and the National Center can play is that of facilitator; put the programs together, put the agencies together, develop a framework that's conducive to cooperation. It is an element that has been badly lacking over the past 3 years.

If there is anything that's worse than a duplication of efforts between agencies, it's a duplication between different parts of the same agency. For example, we would be the last persons to say that there is not a need for training; there is, obviously. There is, however, a duplication of efforts, a gnashing of teeth, a wringing of hands, and a certain amount of confusion when different agencies, funded through the same source offer the same training to the same people in the same geographical area.

I told you that when I was in Denver I was the director of one of the regional resource centers and it drove me crazy. The country is divided into 10 HEW regions. Each HEW region has its own resource center. Each resource center does offer training and technical assistance.

The country was then divided into two halves and a contract was awarded for training in the eastern portion of the country and the western portion of the country. Those contractors then went into each region and offered training. Discretionary funds were given to the regional OCD offices around the country and a number of those regional offices decided to use those discretionary funds for training purposes.

The Federal Government has made a number of awards to agencies and organizations in different States to evaluate training materials by offering training sessions. Of course, States offer training sessions and a number of private organizations offer training sessions.

Telephone calls used to drive me crazy. This month—"Why aren't my people invited? The people from public health have gone to the last four training sessions. When are you people going to put it together?" And I've had to say rather facetiously, "Let me check my plan for coordination, or my plan for prioritization" and there simply wasn't one.

Three: There is a lack of communication. Hypothetically, good communication between different programs and agencies could go a long way toward offsetting the problems of duplication. Unfortunately, there isn't any.

We believe that it is the responsibility of the Federal Government and the National Center to develop the forum to foster and facilitate the exchange of information between recipients of Federal funds.

We realize that perhaps an open dialog is sort of a radical and revolutionary suggestion but, nevertheless, perhaps it could be productive. We believe that at a minimum the directors and associate directors of all major child abuse programs funded through this piece of legislation and through the National Center should meet three to four times a year, and we believe that an open and timely forum created by the National Center would do three things:

One: Provide the National Center with a vehicle to pass along information about program development policy to its clients. Two: Provide the National Center with feedback and evaluation about programs already funded. Three: Provide major child abuse projects with a forum to exchange information, something I wasn't able to do when I was in Denver. I had a burning need to exchange information about common problems, common solutions, strategy and the possibility of piggybacking efforts.

Today, there is a fragmentation of efforts and a duplication of efforts and it is marked in three simple phrases; a failure to communicate, coordinate, and cooperate. Given the fact that the problem is huge and the resources are scarce it would seem to be prudent to identify the areas of fragmentation and duplication. If you identify those areas you could make some minor and some major reallocations.

To accomplish that we believe it is necessary for the Federal Government to define, at least in general terms, what it wants to accomplish and we are willing to call those goals or objectives. We would like to see those goals or objectives put into a coherent form to roughly resemble a national plan or national policy.

I think we have all had enough of Sunday driving. If you are going to have to spend dollars and if you are going to spend taxpayers' dollars wisely, you have to know where you are, you have to know where you want to go, you have to know whether it's worth getting there and you have to know how to get there.

Continual distribution of Federal funds through Public Law 93-247 without the articulation of policy, goals, or reasonable objectives and without a reasonable planning process is going to continue to result in confusion.

We respectfully suggest to this committee that the National Center be required to define its goals for the next 12 months. We would suggest that this bill be extended for only 12 months. We would suggest that future grants and contracts be made on a basis of that plan. We would suggest that present and future programs be evaluated on the basis of that plan and we would suggest that the National Center be evaluated on the basis of the implementation of that plan.

Let me add one more thing, and I think there is almost a consensus of opinion between the witnesses that appeared yesterday, and that's the creation of an advisory board, an advisory council which is composed of individuals outside the Federal Government who can lend expertise, technical assistance, and guidance to the National Center in these trying times.

Thank you.

Senator CRANSTON. Thank you very much.

Do you want to ask any questions or do you want to go on?

Senator HAYAKAWA. I would like to ask some questions.

Mr. Fraser, the overall thrust of your comments that there is lack of coordination and lack of rationale with the many, many programs, you would like to see a national advisory committee established?

Mr. FRASER. Correct.

Senator HAYAKAWA. Do national advisory committees succeed in making rational clusters of irrationally related programs? Do they have that function? Do they do that?

Mr. FRASER. Could they do that?

Senator HAYAKAWA. Are they effective in doing that sort of thing?

Mr. FRASER. I think in some governmental agencies they are. In some private organizations they are, too.

Senator HAYAKAWA. I served on a national advisory committee, that is why I asked the question. I don't think it ever accomplished a thing.

Mr. FRASER. I served on one too that never accomplished anything except sitting around a table talking back and forth with their own axe to grind.

Senator **Hayakawa.** I am sure it is possible for some of them to do so, is it not? I am not totally pessimistic about the value of national advisory committees, but you do see a national advisory committee as being able to bring together that which is scattered, and inconsistent and irrational?

Mr. **Fraser.** Yes; to a certain extent I do but it is a 75–25 proposition. It is also going to require a certain amount of cooperation with the Office of Child Development and the National Center working together in an arena of mutual respect. It can be accomplished.

Senator **Hayakawa.** Which of these organizations you refer to are voluntary organizations and which of these are Government agencies, the National Center?

Mr. **Fraser.** There are two national centers. There is the National Center on Child Abuse and Neglect, which is here in Washington, D.C. That is part of OCD. There is another National Center for the Prevention and Treatment of Child Abuse and Neglect in Denver, Colo. It is a part of the Department of Pediatrics of the University of Colorado Medical Center.

Senator **Hayakawa.** That is not a Federal agency?

Mr. **Fraser.** That is not a Federal agency, that is correct.

Senator **Hayakawa.** And these two offices are in cooperation with each other or do they work at cross purposes?

Mr. **Fraser.** That's where I worked for 3 years. I will try and be nice and say there was a lack of communication between us but not on our part.

Senator **Hayakawa.** There is a National Center on Child Abuse in Washington.

Mr. **Fraser.** That's right, that's the Federal one.

Senator **Hayakawa.** What is the name of the one in Denver?

Mr. **Fraser.** The National Center for the Prevention and Treatment of Child Abuse and Neglect, and it receives some Federal funds and it also receives a rather large grant from the Robert Wood Johnson Foundation and some from the Lilly Foundation, private funds.

Senator **Hayakawa.** Is that part of the university?

Mr. **Fraser.** Yes; it is the University of Colorado Medical Center.

Senator **Hayakawa.** And you are not separating abuse from neglect as two separate problems?

Mr. **Fraser.** No; as a matter of fact I define child abuse to include four elements; the nonaccidental physical injury, neglect, sexual molestation, and emotional abuse or mental injury, and I agree with my colleague that some of these elements are very difficult to define. Child abuse, to a certain extent is like pornography, you know it when you see it but it is awfully difficult to define.

One of the advisory councils I served on we spun our wheels in an attempt to define exactly what child abuse was.

Senator **Hayakawa.** This is why I raised the question the other day as to whether, in the case of that gentleman from Harvard who was testifying, whether there had been any comparative anthropoligical studies, because what may seem to be child abuse from the point of view of one culture may be standard operating procedure in another culture. This is why I raise the question.

Mr. FRASER. I can't give you an answer. I am simply a lawyer.

Senator HAYAKAWA. But we do feel the definition of abuse itself is very difficult conceptually.

Mr. FRASER. The nonaccidental physical injury is fairly easy to define. I think neglect—it's really a standard of behavior to be quite honest. What we are talking about is what standard of care children are entitled to and in America we have never decided exactly what that standard is. There are two conflicting schools of thought; one is represented by Dr. Davil Gil who would say a child is entitled to the care and support that a reasonable, prudent parent would provide.

The other would be represented by Monrad Paulson of the University of Virginia School of Law who says, let's not be ridiculous, a child is only entitled to what the community accepts as a minimum.

We have been going back and forth for the past 20 years. A child is probably entitled to something in between those two. No one has ever really said. It has been debated but never delineated. Yes; it is a difficult thing to define.

As a matter of fact, the way some States get around it is they simply say we require the reporting of nonaccidental physical injury, neglect, sexual molestation and mental injury. That satisfies the requirement of the Mondale bill but it sure leaves open a lot of doors for abuse.

Senator HAYAKAWA. When you say the present program should be continued for only 1 year, you are really being quite critical of the program, are you not?

Mr. FRASER. Yes. I am being critical of the program but I think they are faced with some problems that are difficult to cope with in any growing organization. I know a number of members who serve in the National Center and I respect their capabilities. I basically would like to see a more open agency. The National Center must assume a role of facilitator. There are ten requirements, the requirements my colleague was talking about contained in 4(b)(2). A State has to meet those before it is eligible for Federal funds.

I would do away with those. The fact is we have children out there who are in need of help. I would make every State eligible to receive Federal funds. Right now, the allocation under 93-247 is between 5 and 20 percent. I would up that allocation to 60 percent. I would create an advisory board to give the National Center a little help over the next 12 months.

In the next 12 months I think we need to take a very, very strong look at where the National Center can go, how it fits into other children's programs and how HEW is being reorganized. I would like within the next 12 months to develop a rather comprehensive piece of legislation which could integrate this program into all other children's programs. I would make it a coherent program at the same time.

Senator HAYAKAWA. You make yourself very clear, Mr. Fraser. Thank you very much.

Thank you, Mr. Chairman.

[Prepared statement of Mr. Fraser follows:]

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Prepared Statement for Hearings on the Renewal of the Child Abuse Prevention and Treatment Act, Senate Subcommittee on Child and Human Development.

(April 7, 1977)

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Introduction

It has now been two years since the federal government enacted into law the Child Abuse Prevention and Treatment Act. This Act has resulted in the funding of some good programs and an increased awareness of the problems of child abuse and neglect. There are, however, certain problems that need to be addressed before PL93-247 is renewed.

Problems

One: Lack of Clear and Specific Objectives

The stated purpose of the Child Abuse Prevention and Treatment Act (PL93-247) is to provide funding to help identify, prevent, and treat child abuse and neglect.

It is now necessary to be somewhat more specific about how those goals are to be achieved. Federal funds are now used to support various demonstration projects, regional demonstration resource projects and research projects, with the assumption that they will define their own objectives and these objectives will evolve into national policy and one national program. This has not happened.

We believe that it would be prudent and desirable to define reasonable goals and objectives for the coming year (or the coming three years). If goals and objectives are delineated, it would be possible to define and evaluate current programs in the framework of one coordinated national effort. Furthermore, it would be possible to define areas which are not currently addressed and focus on specific priorities.

In simple terms we would suggest that until you know where you are and until you know where you want to go, it is somewhat difficult to decide in which direction you ought to move. We would suggest that the Federal Government has failed to define its objectives, to delineate its goals and to make known the direction in which it intends to move. There is a substantial difference between funding a well-coordinated program and funding a problem.

Two: A Duplication of Efforts

It is extraordinarily difficult to explain how a particular child abuse system works. There are so many programs and agencies that are directly or peripherally involved, so many responsibilities that are not defined, so many jurisdictions that overlap, and so little direction that most persons who work within that system do not understand how that system functions. There is, however, one indigenous element to all child abuse delivery systems. There is a duplication and fragmentation of efforts on the federal, regional, state and local levels. This duplication and fragmentation could be illustrated on a federal level with a little imagination, four pieces of translucent paper, a black marking pencil, some needles, some thread, a strong light and a strong constitution.

A. On the first piece of paper it is necessary to trace the responsibilities of the individual states. Each state has primary jurisdiction over all matters that concern the health, the welfare, the safety, and the morals of its citizens. These are responsibilities that rest completely with the individual state. The Federal Government has no authorization to override a state's responsibility in these four areas. Child abuse falls within the purview of the individual state's jurisdiction and responsibility.

Every state has created and enacted into law a mandatory reporting statute. Every state has identified at least one statewide agency to receive and investigate reports of suspected child abuse. Every state is required to protect its citizens' health, welfare, safety and morals. The actual protection of these interests varies from state to state. In cases of child abuse, some states simply require that reports be made, identify an agency to receive and investigate those reports, and offer protective services, if available. Other states require reports, identify an agency to receive and investigate reports, offer protective services, and have incorporated into their social service delivery system specific treatment programs for the abused child and his parents. The majority of states, however, fall somewhere between these two extremes.

B. On the second piece of paper, it is necessary to trace the federal framework for dealing with child abuse. Unlike the individual states, the federal government does not have primary responsibility nor primary jurisdiction to deal with the health, welfare, morals, or safety of individual state citizens. Nevertheless, the Federal Government does offer technical assistance, training, and some services in the area of child abuse. For the most part, these flow out of the monies allocated under PL93-247.

The federal framework consists of a National Center on Child Abuse and Neglect in Washington, D.C., 25 demonstration projects, 10 regional projects, and a similar number of research projects. The federal framework can be utilized at the discretion of the individual states.

C. On the third piece of paper, it is necessary to trace the framework of four private national child abuse programs. Like the Federal Government, these programs cannot dictate to a state how its health system or child abuse system will function. Like the Federal Government, these are frameworks that can be utilized at the discretion of the individual states. Unlike the Federal Government, these programs have grown out of a specialized need and have built into them a national constituency with vested interests.

1. The Humane Association: Children's Division, Denver, Colorado. The HA focuses on the development or the improvement of existing protective services. The HA offers training, technical assistance, consultation, program planning and program evaluation in protective services, especially as they relate to child abuse.
2. The National Center for the Prevention and Treatment of Child Abuse and Neglect, U/C/M/C, Denver, Colorado. The National Center in Denver focuses on the development of innovative treatment modalities for the abused child and his parents. The National Center in Denver offers training, technical assistance, consultation, program evaluation, and program implementation in the area of child abuse treatment programs.
3. The National Committee for Prevention of Child Abuse, Chicago, Illinois. The National Committee's primary focus is the preventive aspects of child abuse. Con-

current with this objective is the development of a national public awareness and education campaign and the integration of services. The National Committee offers training, technical assistance, case consultation, legal and legislative advocacy services, and consultation in the area of primary and secondary prevention programs.

4. Parents Anonymous, Redondo Beach, California. PA is a national organization whose primary focus is on crisis management and crisis intervention of abusive parents by abusive parents. There are 600 of these self-help groups throughout the country.

D. There are a number of small privately-funded, demonstration projects spread throughout the country. Funding for these programs comes from affluent individuals, corporations, and smaller foundations. These demonstration projects, unlike the national pro[illegible]s, serve a limited audience, for a limited purpose, in a limited geographical area. For the most part, they offer a direct service and are intended to serve as pilot programs for future duplication.

Each piece of translucent paper should be placed one on top of the other. The edges must be aligned. The four pieces of paper can be held together and placed in front of a strong light. Two things should quickly become apparent. There are dark spots. These dark spots indicate areas in which programs and services overlap. For example, some state agencies offer training in the field of child abuse; the Federal Government offers training in the field of child abuse; all four private national organizations offer training in the field of child abuse; and some of the localized demonstration projects offer training. It is also apparent that there are clear areas -- spots in which the light shines through. These are areas which are devoid of any services or resources. For example, in most states there are no treatment programs for children. In most states there is no public awareness and education campaign concerning child abuse.

Through those dark areas (outlined with a black marking pencil) which indicate overlapping services, one might be inclined to place a pin. That same person might place a needle at the outer edge of each clear area -- those areas which indicate no services and no resources. If you were to thread the needles together, you would schematically draft the perimeters of the problem. The pins within that threaded area mark the starting point for dealing with the problems of child abuse. They indicate a duplication of efforts, a poor allocation of resources, and no integration. They mark a lack of planning, of communication, of cooperation, and of vision. They should also mark the starting point for any federal effort.

Given the fact that resources in this particular field are limited, it would seem to be prudent to identify those areas of duplication and reallocate available resources in a more appropriate manner. This would require at a minimum coordination and cooperation between diverse agencies and programs. A prerequisite to coordination is: (1) the development of one national plan or blueprint with specifically delineated guidelines; and (2) the development of a vehicle to provide for timely and effective communication between all involved agencies.

Three: A Lack of Communication

In the simplest of terms there is a lack of systematic communication between agencies and programs on the federal, regional and state level. Perhaps more important, there is often a lack of communication between different components of the same agency or the same program.

Timely communication between diverse agencies and organizations in the field of child abuse could provide --

- a common base of child abuse data
- identification of common problems and common solutions and
- a sharing of limited expertise and resources.

In a word, systematic communication between concerned agencies and programs could maximize present and potential strengths and minimize present and potential weaknesses.

Four: Child Abuse Has Become Discipline-Oriented

Over the past 15 years child abuse and neglect has come to be regarded as a problem of the Social Worker, the Physician, the Psychiatrist, and the Lawyer. It has to a certain extent become discipline-oriented. Child abuse, however, does not "belong" to any one discipline or any one group of professionals. It could more accurately be defined as a community problem. Its solution requires a commitment from the community. It requires community support.

It is somewhat naive to believe that a few professionals can define the parameters of the problem, develop support, and unilaterally effect a solution. A successful solution requires that the general public accept child abuse and neglect as a serious problem, prioritize that problem, and make a commitment to a solution.

Laws are passed, programs are created, and programs are funded by politicians. Politicians and bureaucrats, in the majority of cases, react to problems. They do not anticipate. If the community views child abuse as a serious problem and believes that it should be prioritized, politicians are likely to react to those beliefs. Realistically the greater the public support, the greater the political support. Pragmatically, the greater the political support, the greater the available resources.

Reaction to the Problems

General: The lack of clear and specific objectives; the duplication and fragmentation of efforts; the failure to provide a vehicle for communication; and the "professionalization" of child abuse, exist at all levels. Since this is a hearing to discuss the renewal of a federal act, we will restrict our comments to federal involvement and PL93-247.

Strong leadership on the federal level, the wise articulation of reasonable objectives, and the development of a cooperative framework for dealing with child abuse can have a profound effect on the problem of child abuse. At the same time, it must be recognized that weak leadership, indecision, a lack of clearly-defined objectives, and a failure to facilitate efforts by federal authorities, can have an equally profound but deleterious result.

What is clearly lacking today is adequate planning for the future. It is now time to develop one national policy, one national blueprint, or one national plan to deal with the problems of child abuse and neglect. In developing that National Policy or that framework in which to function for the next three years, it may be prudent to keep a few items in mind --

- it is somewhat naive to believe that child abuse can ever be completely eradicated; it cannot. It can, however, be substantially reduced and contained.
- Resources are limited. The task is to ensure that resources which are available are reasonably and equitably allocated. There is no room for a duplication or a fragmentation of services.
- There exists today a substantial body of knowledge about child abuse. The task is to identify that knowledge and incorporate it wisely. There is no known reason to reinvent the wheel.

- There are today a number of organizations, agencies and programs which are already working in the field of child abuse. The task is to identify them, provide a vehicle for communication, and help to integrate them.
- There are today agencies, organizations and programs which are not working in the field of child abuse, but could. The task is to identify them and integrate them wisely with other programs.
- There is a large resource which has yet to be formally identified and utilized in the fight against child abuse. That resource is the general public. The active segment of the general public is the volunteer.
- The Federal Government has available limited resources. It could effectively multiply its effect by wisely integrating and coordinating all agencies and programs which are currently functioning, regardless of where the agency or program funding originated. The task is not to fund as many programs as possible, but to effectively maximize what already exists.

One: Specific Objectives

Public Law 93-247 defined its goals as the identification, the treatment, and the prevention of child abuse. It is now time to be somewhat more specific in our articulation of objectives. While it may be deleterious to become too specific, it is not unrealistic to demand the development of one coordinated national child abuse and neglect program. To be effective, it is necessary to go beyond the simple dictates of identification, treatment and prevention.

We believe that it is the responsibility of this Subcommittee and its counterpart in Congress to specifically delineate those objectives. We believe that it is the National Center on Child Abuse and Neglect's (O.C.D.) responsibility to render those objectives into a written form or blueprint for future action. We believe that the blueprint should be made available to any party who requests it. We believe that all future grants or contracts should be justified on the basis of that blueprint. We believe that the components of the plan and the plan should be evaluated at regular intervals by an Advisory Board which is independent of the Office of Child Development. We would respectively point out that until specific objectives are developed and a specific blueprint adopted, it is not possible to evaluate the effectiveness of the National Center on Child Abuse and Neglect and the Office of Child Development. Accountability works both ways.

Two: Duplication of Efforts

It may be simplistic to say, but nevertheless we believe that the development and implementation of a national blueprint or plan to deal with child abuse and neglect could abrogate much of the duplication that exists today. We would suggest that future monies which flow out of PL93-247 be justified on the basis of the defined objectives and national blueprint. A proper and constant monitoring of funded projects should enable N.C.A.N. to identify areas of potential duplication.

The most obvious duplication of efforts in the past has been in the area of training. Originally each Regional Demonstration Resource Project was mandated to provide training to states within its region. The country was then divided into two parts. A contract was awarded to provide training to the Eastern half of the country; another contract was awarded to provide training to the Western half of the country. Following that, special grants were awarded to different agencies in different states to provide additional training. A number of the Regional O.C.D. offices decided to allocate their discretionary child abuse monies for training purposes, and finally many states still conduct their own training sessions.

There is, of course, nothing inherently wrong with different organizations or agencies offering training within a specific geographical area. There is, however, confusion, duplication and fragmentation when different agencies funded through the same source offer training to the same persons within the same geographical area.

The National Center on Child Abuse and Neglect has funded one Regional Demonstration Resource Center in each H.E.W. Region around the country. Each Resource Center was ostensibly chosen because it contained available expertise in the field of child abuse and neglect, and could offer technical assistance and consultative services to the states within its Region. We would suggest that these Regional Resource Centers be utilized to coordinate all child abuse activities (at least in regard to PL93-247 monies) within their regions.

Three: Communication

We believe that it is the responsibility of the National Center on Child Abuse and Neglect (O.C.D.) to develop a forum to foster and facilitate the exchange of information between all recipients of federal funds. We believe that the Directors and Associate Directors of all major child abuse projects should meet three to four times each year. We believe that child abuse projects should have the opportunity to discuss among themselves current problems, solutions to those problems, current programs, and areas where projects might cooperate and maximize efforts.

Well-organized and structured meetings between the project directors of Regional Resource Centers should serve three purposes:

- it would provide the National Center with a forum in which to inform their projects of current policy and activities of the National Center.
- It would provide the National Center with feedback and evaluation from its funded programs. Since the Regional Recource Centers would also serve in the capacity of coordinators for their region, it would provide the National Center with additional information concerning local child abuse activities, and
- it would provide the Resource Centers with a forum to exchange information between themselves: i.e., common problems, common solutions, strategy and cooperation.

Four: The "Professionalism" of Child Abuse

The problem of professionalism in the field of child abuse can be broken into two components: convincing the professionals that child abuse is a community problem that should be shared with the general public, and convincing the general public that child abuse is indeed a problem.

The National Committee for the Prevention of Child Abuse and the Advertising Council Inc. of New York have entered into a three-year agreement to develop a national public awareness campaign concerning child abuse and neglect. The campaign began September 1, 1976. It includes television, radio, newspapers, magazines, billboard, public transportation and public service announcements. If a dollar figure were attached to the campaign, it would be the equivalent of a $10 million public service campaign.

Recognizing the fact that most agencies which are mandated to deal with the problems of child abuse are functioning at or over capacity, the campaign has been specifically designed not to do two things:

(1) to encourage additional reporting, and

(2) to sensationalize the problem.

The public service campaign is designed to do three things:

(1) to tell the general public a little more about the problem of child abuse;

(2) to inform the general public that there are organizations which are currently working in the area of child abuse, and

(3) to provide those persons who are interested in obtaining further information about child abuse with a Box Number in Chicago to which they can write.

The information which has been prepared for persons requesting additional data is rather general in nature. Because this is a National campaign, and since requests will come from all sectors of the country, the prepared material must be as applicable in California as it is in New York, North Dakota, Florida, etc., etc.

The National Committee is fully cognizant of the value of providing specific information about specific programs within specific geographical locations. As requests flow into Chicago, the National Committee has the ability to type two self-affixing labels and segregate those labels according to state. One of the two labels is then affixed to the National Committee's materials and immediately forwarded.

The second label will be made available to individual states, specifically the state agency that is mandated by state law to receive reports of suspected child abuse, to investigate those reports and offer services, if:

- they have child abuse information which is indigenous to their own state.
- they will make that information available free of charge, and
- the names that are forwarded are only used to mail along additional child abuse materials.

Working properly, a resident of Hartford, Connecticut would write Box 2866 requesting additional information. Two labels are typed. One label is affixed to the National Committee's material and forwarded. The second label is forwarded to the state agency in Hartford. The state agency affixes that label to its own material and forwards it. The person who requested the information receives a general information booklet about child abuse from the National Committee and specific information about specific programs within the State of Connecticut.

It is our belief that a public awareness campaign such as this will increase the public's knowledge about the problem of child abuse and neglect. We believe that any viable solution to child abuse requires the denigration of a discipline-oriented approach to child abuse and the encouragement of a community approach to child abuse. We believe that a properly prepared public service campaign will foster a vested interest on the part of the private sector, and will eventually encourage a community approach. We believe that it is in the public's interest and the government's interest to develop one coordinated child abuse public awareness campaign. We respectively direct this Committee's attention to the testimony of our colleague, Dr. V. Fontana, at the Congressional Hearings, concerning the Federal Government's failure to coordinate its activities in the area of public awareness.

Five: General

We believe that it is absolutely imperative to:

1. define specific objectives which can be realistically met within the next 12 months.
2. that national policy be specifically defined, and that a blueprint or a national plan be drafted and enacted to implement that national policy.
3. that future grants and contracts awarded by the National Center be and justified on the basis of that plan, and that the performance of the National Center and O.D.C. be evaluated on the basis of these objectives and that plan.

In simple terms, it is now necessary for us to define where we want to go and how we want to get there. The distribution of federal funds through PL93-247 without the establishment of national policy, the articulation of objectives and the implementation of a planning process, will continue to result in duplication, confusion and fragmentation. With limited resources, confusion, duplication and fragmentation are not deleterious -- they are deadly. We suggest that comments to the effect -- you cannot define objectives or draft policy because it will hamper future efforts, not enough is known, it hasn't worked with other programs, should have died a natural death a decade ago. To the extent that it continues to haunt us, it should be neatly and quickly laid to rest. There is little difference between nonfeasance and misfeasance; the results are exactly the same.

Specific Comments in Regard to Public Law 93-247

We urge that PL93-247 be extended for an additional 12 months with an appropriation of $19,000,000. In light of the fact that H.E.W. is currently passing through a period of reorganization, and that many programs are being reassessed and revamped, it would not seem prudent to extend the bill longer than 12 months. We suggest, however, that minor amendments be made; specifically, we urge:

- that an advisory committee be formed from persons outside H.E.W.
- that the 10 conditions precedent for states which currently exist in 4(b)(2) be made voluntary, and
- that the allocation made available to the states be increased to not less than 60%.

We have attached to this testimony a letter from the Governor of Kansas, the Honorable Robert Bennett. Governor Bennett is the Chairman of the Education Commission of the States' National Advisory Council on Child Abuse and Neglect. The letter contains suggested amendments for PL93-247. Inasmuch as four members of the National Committee's Board of Directors: the Honorable Robert Bennett; the Honorable Lisa Richette, Judge, Court of Common Pleas, Philadelphia; Ms. Donna Stone; Ms. Elinor McGovern; and the National Committee's Executive Director, are members of that National Advisory Council, we would endorse and recommend those amendments.

Finally, we would like to applaud the efforts and the advances that have been made in identifying and treating abused children and their families. We point out, however, that the cost to the American public in terms of actual dollars and human suffering in dealing with the problem after the fact is staggering. One of the original objectives of PL93-247 was the prevention of child abuse. That has been badly neglected.

Senator CRANSTON. Ms. Graham?

Ms. GRAHAM. Thank you.

I would first like to introduce Leila Whiting, who is director of the Child Abuse and Neglect Training grant under the National Association of Social Workers funded through the Office of Child Development.

By way of summary, I would only like to deal with two aspects of the prepared testimony; one, linkages by way of emphasizing and concurring with previous testimony and the other, advocacy, which has not really been dealt with in detail by previous witnesses.

The National Association of Social Workers feels that the National Center on Child Abuse and Neglect should be given a key role in providing a program of linkages between the various governmental funding sources who are working with the same target population.

Just a few of the agencies whose concerns overlap with NCCAN include the National Institute of Mental Health, the National Institute on Drug Abuse, the National Institute of Child Health and Human Development.

A pivotal role would enable NCCAN, then, to accomplish such goals as making substantive recommendations and contributions for consideration at the upcoming White House Conference on Families.

To reduce familial stress and resultant feelings of low self-esteem, therefore, we need to develop coordinated programs, with effective linkages, or comprehensive social services. Vulnerable families who are prone to react to stress with violence, which includes child abuse and neglect, would be a chief target group for such integrated resources.

Such a network of linkages could be envisioned as including liaison with: child abuse and neglect programs; programs for battered spouses; groups advocating techniques of family therapy; and the numerous parent education programs.

In terms of advocacy, in such a system, the National Center on Child Abuse and Neglect could also play a key role of advocacy for all Federal programs involved with family support systems. It could further act as a watchdog for subtle signs of family stress and harm to children and lead the search for methods of immediate intervention.

The recent spate of unconscionable use of children for pornographic purposes is an example of the sort of thing to which we are referring, where NCCAN should have a clear mandate to assume leadership in exposing such practices to the light of the harm they do to children, with suggestions of ways to effectively stop this form of child abuse.

If NCCAN had such a clear mandate, it could have taken such steps as call a press conference to make sure the public becomes aware of this form of child abuse. Call an immediate meeting of concerned national groups and agencies. Lead the development of a concerted plan of action. Seek out and provide discretionary funds to gather facts and devise possible counteractions, and evolve recommendations to local groups for immediate action to correct this clear misuse of children.

In summary, then, NASW supports funding for integrated programs to provide a system of coordinated supports for stressed families, thus focusing on the family as a primary preventive agent in the national effort to eradicate child abuse and neglect.

Thank you.

[The prepared statement of Ms. Graham follows:]

TESTIMONY

BEFORE THE

SENATE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT

PRESENTED BY

VANETTE GRAHAM, SENIOR SOCIAL WORKER
CHILD PROTECTION CENTER
CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER
WASHINGTON, D.C.
AND
CHAIRPERSON
THE CHILDREN'S COALITION

ON BEHALF OF

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC.
1425 H STREET, N.W., SUITE 600
WASHINGTON, D.C. 20005

WASHINGTON, D.C.
APRIL 7, 1977

MY NAME IS VANETTE GRAHAM. I AM A SOCIAL WORKER REPRESENTING THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW), A PROFESSIONAL ORGANIZATION OF OVER 71,000 MEMBERS. IN ALL COMMUNITIES WHERE THERE IS SOME PROGRAM WHICH OFFERS SERVICES TO ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES, THE SOCIAL WORKER IS THE KEY PROFESSIONAL. FOR OVER HALF A CENTURY, SOCIAL WORKERS HAVE BEEN INTIMATELY INVOLVED WITH AND COMMITTED TO HELPING ABUSIVE AND NEGLECTFUL FAMILIES. WE SPEAK TO THE ISSUE BEFORE THIS COMMITTEE TODAY, THEREFORE, AS A PROFESSIONAL BODY WITH A LONG HISTORY OF CONTINUOUS AND INTIMATE INVOLVEMENT IN THE PROBLEMS OF CHILD ABUSE AND NEGLECT.

NASW HAS ALREADY PRESENTED TESTIMONY BEFORE THE HOUSE SUBCOMMITTEE ON SELECT EDUCATION AND WE WOULD LIKE TO HIGHLIGHT A FEW POINTS. IN THE PREVIOUS TESTIMONY, NASW RECOMMENDED CONTINUED FUNDING UNDER THE CHILD ABUSE PREVENTION AND TREATMENT ACT OF 1974 (P.L. 93-247) AND THAT IMPROVED COORDINATION OF ALL SERVICES FOR VULNERABLE FAMILIES BE EXPEDITED TO PREVENT THE PRESENT DUPLICATION OF EFFORT IN VARIOUS FEDERAL PROGRAMS. WE FURTHER RECOMMENDED THAT AS WELL AS MONEY AND EFFORT AIMED AT DIRECT SERVICE PROVISION, OUR KNOWLEDGE BASE BE INCREASED BY RESEARCH INTO BASIC AREAS SUCH AS CHILD REARING PRACTICES, MORE EFFECTIVE WAYS OF ACCELERATING SOCIAL CHANGE, AND METHODS OF DEVELOPING COORDINATED SERVICE DELIVERY TO VULNERABLE FAMILIES. NASW QUESTIONED THE USE OF PRIVATE, PROFIT-MAKING FIRMS TO RECEIVE MONEY FOR RESEARCH AND TO IMPLEMENT HUMAN SERVICE GOALS, THUS JOINING THE GROWING NUMBER OF PROFESSIONALS CONCERNED ABOUT THIS ISSUE.

POLICY ON FAMILIES

IN ORDER TO UNDERSTAND THE PROBLEMS OF CHILD ABUSE AND NEGLECT, THE CHILD'S TOTAL ECOLOGY MUST BE EXAMINED. UNQUESTIONABLY, THE BEST ENVIRONMENT FOR GROWING HEALTHY CHILDREN IS A NURTURING, CARING FAMILY. THE BASIC METHOD, THEREFORE, OF PROTECTING CHILDREN IS TO ENHANCE THE QUALITY OF FAMILY LIFE. BECAUSE OF OUR CATEGORICAL APPROACH TO HUMAN SERVICES AND OUR AMBIVALENCE ABOUT THESE SERVICES, WE IN THE UNITED STATES HAVE BOTH FRAGMENTATION AND DUPLICATION IN MANY OF OUR PROGRAMS, WHICH ARE OSTENSIBLY DESIGNATED TO BE SUPPORTIVE OF FAMILIES. STILL, WE CONTINUE TO LACK A COHESIVE POLICY ON FAMILIES TO GUIDE OUR EFFORTS.

FOR EXAMPLE, WE HAVE THE HEAD START PROGRAMS AND RUNAWAY YOUTH PROGRAMS, AS WELL AS CHILD ABUSE AND NEGLECT PROGRAMS. FAMILIES AND CHILDREN PARTICIPATING IN THESE PROGRAMS ARE OFTEN THE SAME FAMILIES AT DIFFERENT STAGES. THESE PROGRAMS OFTEN EXIST SIDE BY SIDE IN COMMUNITIES WITH LITTLE COMMUNICATION OR COORDINATION AND YET THEIR TARGET POPULATIONS ARE THE SAME VULNERABLE FAMILIES. INTEGRATED SERVICES WOULD BE MORE ECONOMICALLY AND PSYCHOLOGICALLY EFFICIENT AND EFFECTIVE.

WE KNOW THAT IN ORDER TO PRODUCE PSYCHOLOGICALLY AND PHYSICALLY HEALTHY INDIVIDUALS, WE MUST HAVE FAMILIES, OR FAMILY SUBSTITUTES, WHICH PROVIDE A NURTURING, ACCEPTING ENVIRONMENT FOR THE GROWING INDIVIDUAL. CHILD ABUSE AND NEGLECT ARE OFTEN A SYMPTOM OF THE BREAKDOWN IN THE QUALITY OF FAMILY LIFE. PARTICIPATING IN THIS BREAKDOWN ARE OFTEN NUMEROUS STRESSES, SUCH AS: INADEQUATE FINANCIAL RESOURCES, POOR EMPLOYMENT OPPORTUNITIES, LACK OF

EDUCATIONAL RESOURCES, INSUFFICIENT CHILD CARE FACILITIES, ISOLATION OF THE PARENTS FROM THEIR ORIGINAL COMMUNITY, AND LACK OF PSYCHOLOGICAL SUPPORT FOR THE STRESSED FAMILY. WHEN THESE RESOURCES WHICH ARE SUPPORTIVE TO INDIVIDUALS AND FAMILIES ARE LACKING, THEN THE RESULTING PRESSURES ON THE INDIVIDUALS WITHIN THE FAMILIES MAY EASILY RESULT IN FAMILIES MAKING USE OF ANOTHER RESOURCE TO EXPRESS THEMSELVES, NAMELY, VIOLENCE. TOO OFTEN THIS VIOLENCE IS DIRECTED AT THE PERSON LOWER IN STATUS THAN THE BELEAGURED PARENT: THE CHILD.

LINKAGES

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (NCCAN) HAS BEEN ESTABLISHED TO FOCUS ON ONE ASPECT OF FAMILY BREAKDOWN. THIS IS, HOWEVER, AN ARTIFICIAL ISOLATION; IN ORDER TO BE MAXIMALLY EFFECTIVE IN DEALING WITH CHILD ABUSE AND NEGLECT, NCCAN SHOULD BE GIVEN A KEY ROLE IN PROVIDING A PROGRAM OF LINKAGES BETWEEN THE VARIOUS GOVERNMENTAL FUNDING SOURCES WHO ARE WORKING WITH THE SAME TARGET POPULATION. JUST A FEW OF THE AGENCIES WHOSE CONCERNS OVERLAP WITH NCCAN INCLUDE: THE NATIONAL INSTITUTE OF MENTAL HEALTH, THE NATIONAL INSTITUTE ON DRUG ABUSE, THE NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT. A PIVOTAL ROLE WOULD ENABLE NCCAN, THEN, TO ACCOMPLISH SUCH GOALS AS MAKING SUBSTANTIVE RECOMMENDATIONS AND CONTRIBUTIONS FOR CONSIDERATION AT THE UPCOMING WHITE HOUSE CONFERENCE ON FAMILIES.

TO REDUCE FAMILIAL STRESS AND RESULTANT FEELINGS OF LOW SELF-ESTEEM, THEREFORE, WE NEED TO DEVELOP COORDINATED PROGRAMS, WITH EFFECTIVE LINKAGES, OF COMPREHENSIVE SOCIAL SERVICES. VULNERABLE

FAMILIES WHO ARE PRONE TO REACT TO STRESS WITH VIOLENCE, WHICH INCLUDES CHILD ABUSE AND NEGLECT, WOULD BE A CHIEF TARGET GROUP FOR SUCH INTEGRATED RESOURCES.

SUCH A NETWORK OF LINKAGES COULD BE ENVISIONED AS INCLUDING LIAISON WITH:

1. CHILD ABUSE AND NEGLECT PROGRAMS
2. PROGRAMS FOR BATTERED SPOUSES
3. GROUPS ADVOCATING TECHNIQUES OF FAMILY THERAPY
4. THE NUMEROUS PARENT EDUCATION PROGRAMS

ADVOCACY

IN SUCH A SYSTEM, THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT COULD ALSO PLAY A KEY ROLE OF ADVOCACY FOR ALL FEDERAL PROGRAMS INVOLVED WITH FAMILY SUPPORT SYSTEMS. IT COULD FURTHER ACT AS A WATCHDOG FOR SUBTLE SIGNS OF FAMILY STRESS AND HARM TO CHILDREN AND LEAD THE SEARCH FOR METHODS OF IMMEDIATE INTERVENTION.

THE RECENT SPATE OF UNCONSCIONABLE USE OF CHILDREN FOR PORNOGRAPHIC PURPOSES IS AN EXAMPLE OF THE SORT OF THING TO WHICH WE ARE REFERRING, WHERE NCCAN SHOULD HAVE A CLEAR MANDATE TO ASSUME LEADERSHIP IN EXPOSING SUCH PRACTICES TO THE LIGHT OF THE HARM THEY DO TO CHILDREN, WITH SUGGESTIONS OF WAYS TO EFFECTIVELY STOP THIS FORM OF CHILD ABUSE.

IF NCCAN HAD HAD SUCH A CLEAR MANDATE, IT COULD HAVE TAKEN SUCH STEPS AS:

1. CALL A PRESS CONFERENCE TO MAKE SURE THE PUBLIC BECOMES AWARE OF THIS FORM OF CHILD ABUSE.
2. CALL AN IMMEDIATE MEETING OF CONCERNED NATIONAL GROUPS AND AGENCIES.

3. LEAD THE DEVELOPMENT OF A CONCERTED PLAN OF ACTION.
4. SEEK OUT AND PROVIDE DISCRETIONARY FUNDS TO GATHER FACTS AND DEVISE POSSIBLE COUNTER-ACTIONS.
5. EVOLVE RECOMMENDATIONS TO LOCAL GROUPS FOR IMMEDIATE ACTION TO CORRECT THIS CLEAR MISUSE OF CHILDREN.

IN SUMMARY, THEN, NASW SUPPORTS FUNDING FOR INTEGRATED PROGRAMS TO PROVIDE A SYSTEM OF COORDINATED SUPPORTS FOR STRESSED FAMILIES, THUS FOCUSING ON THE FAMILY AS A PRIMARY PREVENTIVE AGENT IN THE NATIONAL EFFORT TO ERADICATE CHILD ABUSE AND NEGLECT.

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS
CHILD ABUSE AND NEGLECT TRAINING PROJECT
1425 H STREET, N.W., SUITE 600
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THE NATIONAL ASSOCIATION OF SOCIAL WORKERS (NASW) IS THE LARGEST PROFESSIONAL SOCIAL WORK ORGANIZATION IN THE WORLD, WITH 71,000 MEMBERS IN 54 CHAPTERS THROUGHOUT THE UNITED STATES, PUERTO RICO, AND EUROPE. IN ALL COMMUNITIES WHERE THERE IS SOME PROGRAM WHICH OFFERS SERVICES TO ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES, THE SOCIAL WORKER IS THE KEY PROFESSIONAL, AND HAS BEEN SINCE THE INCEPTION OF SUCH PROGRAMS. IT WAS A NATURAL EXTENSION OF THIS INVOLVEMENT, THEREFORE, WHEN NASW WAS AWARDED A GRANT FROM THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (IN HEW'S CHILDREN'S BUREAU) TO HELP FIELD-TEST A NEWLY DEVELOPED CURRICULUM IN IDENTIFICATION, REPORTING, AND CASE MANAGEMENT OF CHILD ABUSE AND NEGLECT.

THE NASW PROJECT, A ONE-YEAR PROGRAM FROM SEPTEMBER, 1976, IS A MULTI-FACETED ONE. THE CURRICULUM TO BE FIELD-TESTED IS CALLED "WE CAN HELP..." AND WAS DEVELOPED BY A CONSULTING FIRM UNDER A PREVIOUS NCCAN GRANT. IT IS A COMPREHENSIVELY DRAWN CURRICULUM AND SYLLABUS, AND INCLUDES ITS OWN NEW AUDIO-VISUAL COMPONENTS - FILMS AND FILM STRIPS.

THE NASW PROJECT IS IMPLEMENTING THE TRAINING THROUGH ITS STATE CHAPTERS IN THE FORM OF 5-DAY WORKSHOPS, EACH CONSISTING OF 20 HOURS OF TRAINING. THE FIRST STEP WAS TO HAVE A TRIAL WORKSHOP IN THE WASHINGTON, D.C. AREA, WITH TWO TRAINERS WHO WORKED WITH THE PROJECT DIRECTOR TO DEVELOP THE SPECIFIC PROGRAM. EIGHT NASW CHAPTERS WERE THEN SELECTED AS TRAINING SITES, AND

EACH SELECTED CHAPTER NOMINATED SUITABLY QUALIFIED TRAINERS. TWO SUCH TRAINERS WERE SELECTED FROM EACH OF THE EIGHT CHAPTERS, AND A TRAINING WORKSHOP WAS HELD FOR THESE TRAINERS. AT THIS TIME THEY WERE FAMILIARIZED WITH THE TRAINING MATERIAL, WERE ENABLED TO PRACTICE TRAINING SKILLS, AND TO PLAN THE WORKSHOPS FOR THEIR PARTICULAR REGIONAL NEEDS.

ALL OF THE WORKSHOPS HAVE NOW BEEN PLANNED AND THE FIRST ONES HAVE BEEN SUCCESSFULLY COMPLETED. ALTHOUGH THE WORKSHOPS ARE BEAMED PRIMARILY AT SOCIAL WORKERS IN MANY SETTINGS, PARTICIPANTS SO FAR HAVE ALSO INCLUDED MANY OTHER RELATED PROFESSIONALS SUCH AS NURSES, PSYCHOLOGISTS, LAWYERS, LAW ENFORCEMENT PERSONNEL, EDUCATORS, AND THE CLERGY.

A SECOND COMPONENT OF THE NASW PROJECT IS TO ENCOURAGE ALL WORKSHOP PARTICIPANTS TO DUPLICATE RELEVANT SECTIONS OF THE TRAINING PROGRAM IN THEIR OWN AGENCIES, A SO-CALLED MULTIPLIER EFFECT. TO THIS END, A GREAT DEAL OF THE CURRICULUM MATERIAL HAS BEEN REPRODUCED AND FURNISHED TO EACH WORKSHOP PARTICIPANT. THE PROJECT STAFF, AND AT THE LOCAL LEVEL, THE TRAINERS, ARE AVAILABLE TO CONSULT AND ASSIST IN THIS IN-SERVICE ENDEAVOR.

AS WELL AS DIRECT AND INDIRECT TRAINING APPROACHES, THE THIRD COMPONENT OF THE NASW PROJECT IS TO WORK WITH THE COUNCIL ON SOCIAL WORK EDUCATION TO ENCOURAGE SCHOOLS WITH GRADUATE AND UNDERGRADUATE PROGRAMS IN SOCIAL WORK EDUCATION TO INCLUDE THE CHILD ABUSE AND NEGLECT CURRICULUM IN THEIR COURSE OFFERINGS. THE MATERIAL LENDS ITSELF TO BEING IMPLEMENTED AS A REGULAR 3 CREDIT HOUR SEMESTER COURSE, OR TO HAVING RELEVANT UNITS EXCERPTED AND INCLUDED IN OTHER COURSES, OR FOR CONTINUING EDUCATION COURSES.

THE FINAL COMPONENT IN THE NASW PROJECT IS TO WORK CLOSELY WITH OTHER NATIONAL ORGANIZATIONS WHOSE MEMBERSHIP INCLUDES A SIGNIFICANT NUMBER OF SOCIAL WORKERS TO ENCOURAGE THEM TO INCLUDE A SEGMENT OF THE CURRICULUM AS A PANEL OR WORKSHOP AT NATIONAL MEETINGS OR CONFERENCES. SUCH NATIONAL ORGANIZATIONS AS THE NATIONAL CONFERENCE ON SOCIAL WELFARE, AMERICAN ASSOCIATION OF MARRIAGE COUNSELORS, AMERICAN PUBLIC HEALTH ASSOCIATION, FAMILY SERVICE ASSOCIATION OF AMERICA ARE AMONG THOSE WITH WHOM NASW IS CONSULTING FOR THIS PURPOSE.

FOR FURTHER INFORMATION REGARDING THE TRAINING PROJECT, CALL LEILA WHITING, THE PROJECT DIRECTOR, AT (202) 628-6800.

Senator **Cranston**. Thank you very much. I appreciate the testimony of all three of you. I do have a few questions I would like to address to you. Mr. Fraser already answered this but I would like to ask the others of you whether you think the act should be renewed for 1 year or more, and your reasons for that?

Why don't you start, Ms. Graham.

Ms. **Whiting**. NASW is recommending that the act be renewed. We are not putting any monthly limit on the renewal. We would like to see, however, as previous testimony has suggested that integrated services be adequately funded so that the problems that child abuse and neglect represent can be eradicated. There is no way to do away with child abuse and neglect without having a look at the underlying problems of which these are just a symptom.

We would like to see adequate funding for all the programs that will help with that. You need clear goals and a clear understanding of how to eradicate it before just refunding a specific program, so it isn't that we would like to see fewer dollars or fewer months' extension of a particular program but that we would like to see a more cohesive and comprehensive program permanently funded.

Senator **Cranston**. Mr. Bricker, what are your thoughts on the 1 year extension?

Mr. **Bricker**. We support the administration's request, partly out of practicality. As I said in my testimony, our principal concern is the breadth of governmental intervention in family life and that is a pretty broad difficult concept to deal with. Given the fact that the House has more or less decided what it is going to do on this legislation, it looks like next year is the time to address the concerns which we raised. Out of practicality we support the 1 year request.

Senator **Cranston**. If any of you have any suggestions as to substantive changes which should be made, even if it is only extended for 1 year, which can be implemented in that short a period I would like to hear your thoughts.

Mr. **Fraser**. I said the country is divided into 10 HEW regions and there is a regional resource center in each one of those regions. I think perhaps we should begin to utilize those resource centers in a more prudent manner. They could be utilized as a coordinating vehicle for activities within their region.

Set up properly, they should contain enough expertise to be able to offer technical assistance and consultative services to the individual States. Hypothetically, if this bill was functioning properly or if you could make it function properly, the expertise and money would flow to the regional resource centers and the regional resource centers would transfer the expertise to the individual States and the States themselves would begin to develop the expertise to handle the problem themselves: to develop their own programs and implement them into their own service delivery systems.

The fact is child abuse is a community problem. There are 3,342 counties in the country. It is very difficult to coordinate that or to understand the problems on a county level when you are dealing in Washington, D.C.

Senator **Cranston**. Any other comments on that particular point?

Ms. Whiting. I dont' know if this is a particularly substantive comment but it seems to me unless our whole community, the whole Nation is concerned about children and willing to put its money where its concern is, we are not going to make any kind of dent on the problem whatsoever.

A lot of the counties who are required by law to investigate problems of child abuse and neglect, as we heard in previous testimony, have not put additional funds into that investigation nor into a provision of service, instead, turning to the Federal Government and saying why don't they give us more money.

Really, what it boils down to is a lack of concern on the individual's part and a lack of conviction that we need to bring our children up in a different way than they have been brought up previously. We are really looking at a changing pattern of rearing children and a changing way of looking at children, and that has to come first before we are willing to commit our resources to it.

I have no specific suggestions at this point but I would like to see some kind of program that helps the total community understand the needs of children and recognize that families are a very key factor in bringing children up so that a family policy on the part of the Federal Government would go a long way to helping the problem of child abuse and neglect.

Ms. Graham. I would also like to concur with the comments made by Mr. Fraser. I think one of our concerns has been the way contracts have been awarded through the National Center on Child Abuse and Neglect with private firms who might have expert proposal writers getting grants, but whose expertise is not in the proposed area. This is something that I would like to see changed as per the remarks made by Mr. Fraser.

Senator **Cranston.** Do you have any suggestions to make in regard to this? If you were rewriting the bill, what percentage of funds would you allocate to various types of programs such as, research, demonstration projects, services, State programs, et cetera? Mr. Fraser did say he would give 60 percent to State programs. Do you have any other comments on that?

Mr. Fraser. I would just add an addendum and say I do agree with the percentiles that were included with Dr. Kempe's testimony. I do believe that is a portion of the record that was presented yesterday.

Senator **Cranston.** Are there activities supported under the act which should no longer be funded by the Federal Government? For example, should the Federal Government continue to support training curriculum development, public works and that sort of thing?

Ms. Whiting. Yes, I think they should continue to fund them but only if there is a clear coordinated effort and a clear lack of duplication. Duplication is not necessarily twice as good. It oftentimes reduces the effectiveness rather than enhancing it, and if we are going to have to continue funding of anything, I would agree with Mr. Fraser, there needs to be clear goals and there needs to be clear coordination and communication amongst the organizations which are effecting those goals.

Mr. **Fraser.** We would agree. We are still at a loss to understand why there are two public awareness campaigns. We believe public awareness is an integral part in the beginning of any good program for prevention of child abuse. We feel that perhaps by piggybacking those efforts we would go a lot further toward resolving the issue as opposed to having two separate organizations functioning in two different parts of the country in two different public awareness campaigns.

We are terribly interested in Mr. Rosoff's written explanation for what happened. The training, I think, is necessary. I think we spent enough money developing training materials. They may have to be brushed up a little bit but I think we have enough material available to us now to provide adequate training for the professionals and paraprofessionals in the field.

It would be a terrible waste of money to spend additional funds to develop new training materials.

Ms. **Graham.** As an employee of a demonstration project I would concur, but I was a little alarmed at the response from the officials from HEW in terms of continuing these projects. I feel that service-giving is an important aspect of NCCAN's focus and function for the community, and training along with service should be given a great deal of consideration.

Senator **Cranston.** Thank you very much. I have no more questions. You have been very helpful and responsive. I appreciate it greatly. I thank all those who participated and attended this hearing.

We will now adjourn the hearings and be working on the bill and mark up. Thank you very much.

[Whereupon, at 11:32 a.m. the subcommittee adjourned.]

APPENDIX

I.—Additional Statements

II.—Additional Communications

III.—Background Materials

L—ADDITIONAL STATEMENTS

Testimony of

RAYMOND W. VOWELL, COMMISSIONER

State Department of Public Welfare

The State of Texas

prepared for the Subcommittee on Children and Human Development,

Senate Committee on Human Resources,

U. S. Senate *

Hearings on Public Law 93-247

Child Abuse and Neglect Act

As the agency designated by the Governor of Texas to administer funds allocated to the states under Public Law 93-247, and as the agency designated to administer funds allocated under Titles IV-B and XX of the Social Security Act, the Texas State Department of Public Welfare offers the following testimony in relation to extension of Public Law 93-247.

The intent of this legislation appears appropriate as a means of calling attention to the growing problems occurring as a result of abuse and neglect of children in this country. The vehicles for use of the funds appropriated also appear appropriate in principle.

The administration of this Act appears to have been mishandled in some respects. This agency speaks from direct experience with regard to the provisions of Section 4(b), Grants to States, and from observation and limited direct experience with regard to the provisions of Section 4(a) for demonstration programs and projects.

The Act calls for the expenditure of not less than 50% of the amount appropriated under the Act to be used to comply with the requirements of Section 4(a). An impressive list of grants is available for review. To our knowledge, some of these have been effective and have added or will add to the improvement of services to prevent or treat abuse and neglect. Some of the grants, especially those for training have, as experienced by this agency, been of poor quality and ineffective.

It is with the administration of Section 4(b) that this agency wishes to express its serious concern based on first hand knowledge. This aspect of the legislation has, in the opinion of this organization, been mishandled from the beginning and still has not overcome many of the problems.

To begin with, proposed regulations were published on August 28, 1974, after a January 31, 1974, effective date for the legislation. Initial information and application forms relating to compliance were issued to the states by the Assistant Secretary for Human Development under date of November 21, 1974. The compliance statement and applications for funds for FY 1974 (under an extended granting date to December 31, 1974) authorized by Congress were due in the regional offices of the OHD by December 10, 1974.

The compliance statement is exceedingly long and complicated. Its complications are enhanced by the fact that the regulations (issued as final on December 19, 1974) contain requirements that go beyond the provisions of Public Law 93-247. Beyond this, the regulations and application forms were accompanied by yet another set of instructions which, in more than a few aspects, imposed requirements beyond even the regulations. In its Report to the President and Congress dated August 1975[1], the OHD states, "Section 4(b)(2) of the Act lists ten requirements which a State must meet in order to qualify under Section 4(b)(1). Regulations published December 19, 1974, further interpret these requirements. HEW Form 627, Eligibility Statement for State Child Abuse and Neglect Grant Programs, provides even further interpretation by rephrasing each regulation into questions and explaining how the State can meet the regulation. Some of the requirements can be met only by being enacted into the State's legislation. Some can be met through administrative procedures, and some can be met by a statement from the Governor." This "helpful" expansion created a tightening network of compliance requirements which go far beyond the law.

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[1] Report of the U.S. Department of Health, Education, and Welfare to the President and Congress of the United States on the Implementation of Public Law 93-247, the Child Abuse Prevention and Treatment Act, U.S. Department of Health, Education, and Welfare, Office of Human Development/Office of Child Development/Children's Bureau, Washington, D.C., August 1975.

Texas is still trying to untangle administrative nit-picking, "rephrased regulations," regulations, and law in its effort to comply. At times the effort hardly seems worthwhile. It involves securing Attorney General's opinions and, in some cases, even Governor's assurances of compliance with the law, to qualify for the $176,000 allocated to Texas for Fiscal 1976. This should be considered in the context that the Department is spending some $40.5 million in FY 1977 for Child Protective Services under its Title XX program and in excess of $3 million under Title IV-B. Its legislation under a revised Family Code preceded the federal legislation by one month, having become effective January 1, 1974. The Committee may be interested in the unsolicited report published in the "Child Protection Report" in its issue of August 26, 1976 (copy attached).

NCCAN reported that by the end of FY 1976 twelve additional states ha' qualified under Public Law 93-247, bringing the total to 28 states. But, alas, of the twelve, eight still had only "conditional" approval as late as January 1977. Those states are: California, Georgia, Louisiana, Michigan, New Jersey, South Dakota, Texas, and Washington. No money is available until these "conditions" are removed. The net effect, of course, is that the states have not, indeed benefited as yet from the funds available under this legislation. An interesting sidelight is found in the fact that Alabama, at the same time it was found to be qualifying under Public Law 93-247 for FY 1976 was in the process of having its neglect laws struck down by a three-judge U.S. District Court panel as being "unconstitutionally vague."

The recently announced reorganization within the Department of Health, Education, and Welfare which abolished Social and Rehabilitation Services and placed administration of Title XX and IV-B in the Office of Human Development has implications in terms of the administration of Public Law 93-247 and Titles XX and IV-B. Logically the programs should be administered in close coordination with each other. This is especially true of Section 4(b) of Public Law 93-247. Title IV-B requires that program to be administered by the same agency as that administering the Title XX program. As a rule this is also the agency which would be designated to administer states services under Public Law 93-247. As reorganization plans develop these three programs should be tied closely together for administration. Based on the established cooperative relationships between former SRS components and the states and the unsatisfactory performance of the National Center on Child Abuse and Neglect in relation to the states it is to be hoped that functions of these three legislative mandates can be tied together under the leadership of former SRS components.

In summary, the State of Texas supports the extension of Public Law 93-247. It would recommend the following modifications:

1. Revision of legislation so as to allocate a larger portion of funds to actual program operation rather than to demonstration and training.
2. Placement of the administration of Part 4b of Public Law 93-247, Title XX, and Title IV-B in an administrative unit which carries over program expertise from the former SRS organization.
3. A careful review of provisions in the law which have been identified as deterrents to compliance by states.
4. If such provisions are found to be unnecessarily restrictive that they be modified.
5. That the administering agency be instructed to review and modify its requirements for state compliance so that states can be encouraged to upgrade their programs for abused and neglected children.
6. That the administering agency be instructed to establish appropriate policies and controls with regard to the purposes for which demonstration programs and projects are funded and the competency of the organizations to which grants are awarded.

STATEMENT OF SENATOR WENDELL R. ANDERSON ON THE "CHILD ABUSE PREVENTION AND TREATMENT ACT" BEFORE THE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT COMMITTEE ON HUMAN RESOURCES

Mr. Chairman, in 1973 the Congress responded readily and responsibly to one of the most tragic, perplexing problems afflicting the American family--child abuse and neglect. At that time the incidence of child abuse was still a frightening mystery. It was suggested that the identified cases of child abuse only represented a small percentage of what was actually occurring, and although we still do not have hard data on its prevalence, every day our worst fears are being confirmed. Projections indicate that close to 1 million children suffer from abuse and neglect in this country today, and we are only too painfully aware of the details of case after case of its small victims.

The "Child Abuse Prevention and Treatment Act," which is due for extension, has been an essential first step in combatting this violence against children, but few would question the work that still remains to be done. I commend the Subcommittee for its thorough review of the program's accomplishments and shortcomings, and for asking the questions that must be asked about how to proceed with this critically important mission.

I will look forward to working with you and the Subcommittee members in your continuing efforts in prevention, identfication and treatment of child abuse and neglect.

STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka

ROBERT F. BENNETT
Governor

December 6, 1976

Dr. Sharlene P. Hirsch, Coordinator
Education and Human Development Group
HEW Team, Transition Planning Group
P. O. Box 2600
Washington, D. C. 20013

Dear Dr. Hirsch:

The Education Commission of the States' National Advisory Committee on Child Abuse and Neglect is a non-partisan group composed of recognized leaders in the legislative and executive branches of state and local government, experts from the field of medicine, law, education, social work and law enforcement, and parents and volunteer organizations. At the December 3 and 4, 1976 meeting of the Committee, we unanimously decided to respond to your request for legislative and organizational options, specifically relating to the Child Abuse Prevention and Treatment Act which is coming up for reauthorization.

We urge that the incoming Administration and the Congress reaffirm and continue its concern for the plight of our country's neglected and abused children by reauthorization of Public Law 93-247.

We strongly recommend that the following five modifications be enacted in that law to permit that act to more affirmatively serve the needs of children it purports to assist.

(1) It is recommended that not less than 75% of the total sum appropriated under this act for any fiscal year be allocated for distribution to the states for the specific purpose of assisting the states in developing, strengthening and carrying out child abuse prevention and treatment programs.

Rationale

The most pressing need identified by states is the need for additional funds to make possible the promotion, improvement and expansion of services designed to respond to reports of suspected cases of neglect and abuse. Additional funds are needed for training of personnel engaged in the various disciplines involved in identification and treatment of these social ills. The reality of rising caseloads resulting from improved casefindings and/or from an increase in the incidence itself cries out for the kind of relief which can only be met by a corresponding recruitment of additional personnel.

(2) It is recommended that criteria for state eligibility for grants in this area be relaxed by modifying mandated requirements to permissive guidelines. Specifically, it is suggested that the phrase in section 4(b)(2) of the act reading: "In order for a state to qualify for assistance under this subsection, such state shall ____" be modified by changing the last word "shall" to "should substantially." Additional change is suggested in section 3 which reads: "For purposes of this act the term 'child abuse and neglect' means:" should be changed to read: "For purposes of this act the term 'child abuse and neglect' may include:."

Rationale

With the earlier recommendation that not less than 75% of the appropriation under this act for any fiscal year be allocated for state grants to meet the desperate need for more adequately funding necessary services, it becomes imperative for states to be permitted to qualify more readily. The change in phrasing should not be regarded as an abandonment of goals on behalf of children, but as a relaxation of one set of criteria to permit more rapid development of services to meet the criteria of children's need for immediate help, help which could be denied them if state programs were not sufficiently funded.

(3) It is recommended that not less than 20% of the appropriation under this act for any fiscal year be used for grants to institutions of higher learning or to private, non-profit organizations for the conduct of research or the operation of resource centers and demonstration projects.

Rationale

Concensus seems to agree that there should be continued support of resource center activities, as well as a continuation of research and demonstration grants. However, these should be continued with much more careful screening of utility and need, with funding limited to more meaningful and less duplicative projects.

(4) It is recommended that $475,000 of the appropriation under this act be allocated for use in support of the activities of an Advisory Board set up as recommended herein (over 3 years).

It is recommended that an Advisory Board composed of 25 persons be appointed by the Secretary. The Board would meet regularly, in no event less than twice each year. They would advise and assist in coordinating programs of NCCAN under this act and should advise and assist in the development of federal standards and guidelines for child abuse and neglect. They would also provide an annual report to HEW secretary.

> Composition of the Board should consist of eight persons who should be appointed from NCCAN funded projects. The remainder should be persons knowledgeable in the field of child abuse and neglect with representation from disciplines related to prevention or treatment. Membership on the Board should extend for the life of the act, but in no event for a period longer than three years.

Rationale

The present structure of an Advisory Board draws its membership solely from representatives of federal agencies. That pattern bars input from other informed persons and agencies not within the federal system. The proposed format enlarges the scope of advisory input by incorporating grantee agency representatives and non-federal agency participants.

> (5) The Committee also recommends future legislation allocate more resources to prevention programs. Specifically the Committee believes that parent education be offered through the public schools, continuing education, adult education, and community center schools.

Rationale

It is our judgment that over time, appropriate parenting skills would drastically reduce the incidence of child abuse and neglect.

We respectfully request that you take these recommendations under serious advisement. If we may be of further assistance, please let us know.

***

Chairman:
The Honorable Robert F. Bennett
Governor of Kansas

Ms. Grace Baisinger
First Vice President
National Parent-Teacher Association
Washington, D.C.

Mrs. Otis R. Bowen
Indiana

Mrs. M. Elizabeth Chitty
President
Board of Education
Plainfield, New Jersey

The Honorable Robert Davis
State Representative and Chairman,
Education Committee
Tennessee

Mr. Vincent DeFrancis
American Humane Association
Children's Division
Colorado

Mr. Brian Fraser, Executive Director
National Committee for Prevention
of Child Abuse
Chicago, Illinois

Frederick C. Green, M.D.
Children's Hospital
Washington, D.C.

Dr. Floyd Hall
Superintendent
Greenville County School District
South Carolina

John Himelrick
Interagency Council for Child
Development Services
West Virginia

Dr. Donald F. Kline
Department of Special Education
Utah State University

Ms. Pam S. Levin
Vice President
Citizens' Committee for Children of
New York, Inc.

Ms. Leila Lewis
State Department of Education
Boise, Idaho

The Honorable Anne Lindeman
State Senator
Arizona

Mrs. Eleanor McGovern
Washington, D. C.

The Honorable Jan Meyers
State Senator
Kansas

Dr. Edward C. Pomeroy
Executive Director
American Association of Colleges for
Teacher Education
Washington, D.C.

The Honorable Lisa Richette
Judge, Court of Common Pleas
Philadelphia, Pennsylvania

Ms. Barbara J. Sabol
Director
Division of Services to Children
and Youth
Topeka, Kansas

Carl Scott
Associate Executive Director
Council on Social Work Education
New York City

Mr. Gene Sell
Assistant Principal
Campbell County High School
Kentucky

Ms. Donna J. Stone
President
National Committee for Prevention
of Child Abuse
Illinois

Dr. Duane Thomas
University of Kansas Medical Center

Dr. Michael D. Usdan, President
The Merrill-Palmer Institute
Detroit, Michigan

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
Statehouse
Boise, Idaho 83720

May 17, 1977

Honorable Allen Cranston
U. S. Senate
Chairman Subcommittee on Child and
Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

The following comments are submitted as testimony from the State of Idaho on extension of The Child Abuse Prevention and Treatment Act.

The Act and the creation of the National Center has served to stimulate emphasis and community concern for the abused and neglected child at both the state and national levels. However, in order to address this pressing need, it has been necessary for Idaho to reduce other essential services to adults and families.

The funding under Public Law 93-247 has produced some innovative approaches to the problems of children through the findings of the various contracts awarded. It has also produced training opportunities for our staff. The amount of money available to states however to effectively utilize the new approaches has been inadequate and, in Idaho, nonexistent through P.L. 93-247. The rigid criteria for qualifying for the state allocations and the minimal amount of money available to Idaho, if we should meet the criteria, have discouraged us from attempting to comply. The most difficult criteria to meet is the guardian ad litem requirement. Generally speaking, there is support of the concept, and some of Idaho's judicial districts have assumed the costs. In a rural county, however, the financial burden for legal services for the parents is a heavy one, and adding a guardian ad litem for the child taxes county resources more than some are able to assume at this point. Funds earmarked for this purpose would encourage counties to provide this service.

We would therefore recommend that a larger percentage of the total sum appropriated be distributed to the states to strengthen the child protection delivery system and that states in "substantial" compliance be permitted to utilize the funds.

We would also recommend that funds authorized under Title IV-B of the Social Security Act be increased. An increase in this funding, which was specifically designed for Child Welfare Services, would relieve the heavy drain on Title XX expenditures in Child Protection Services and would release more of the Title XX monies for the needs of the elderly and the handicapped.

Extension of P.L. 93-247 will serve to meet the crucial needs of the abused and neglected children, and we urge your support for the measure.

Sincerely,

Milton G. Klein
Director

MGK/me

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714-744 P STREET
SACRAMENTO, CALIFORNIA 95814
(916) 445-7653

April 1, 1977

Honorable Alan Cranston
Chairman
Subcommittee on Child and Human Development
Suite 4230, Dirksen Senate Office Building
Senate Committee on Human Resources
Washington, D.C. 20510

Dear Senator Cranston:

I regret that I cannot be present in Washington to deliver this testimony on P.L. 93-247. The State of California was pleased with the opportunities which the Act appeared to offer to develop and improve services for abused and neglected children, but we have been disappointed in the lack of benefit from the bill.

Although California was notified on March 28, 1977 that the State has complied with the special conditions placed on the Child Abuse and Neglect grant so that funds should be released within three weeks, we have reservations about the administration of the funds authorized by P.L. 93-247. We applied for a state grant as soon as it was possible to do so, in December 1974. The law was enacted in January 1974. We believe that the delay in accepting applications was a warning of future activities. It has taken almost three years to meet the special conditions imposed on California by the interpretations given the Act by persons in the National Center on Child Abuse and Neglect.

In respect to the specific purpose of this hearing we support the intent of P.L. 93-247 with the following changes:

California would prefer that the Act be extended through Fiscal Year 1980. This would give greater assurance that federal funds would be available to support the much delayed State Office of Child Abuse Prevention.

The authorized funding should not be reduced below $25 million, and the full amount should be appropriated.

The allocation to the states should be increased to at least 50 percent of the appropriation. The present 20 percent is not adequate. If the present qualifying states shared equally in the 20 percent ($5,000,000), it would mean grants of $178,000 per state. If all 50 states qualified, each state's equal share would be $100,000. California has been allocated $269,953 for one year, but this is not an adequate amount to carry out a significant project in such a large and populous state.

In order to coordinate the demonstration and research grants under the Act, and to make such activities more useful to the states and to the children to be served, the bill should provide for establishment of regional centers on child abuse and neglect with one such center in at least each of the states with the highest child population. Such centers would make technical assistance and the results of research and demonstration projects readily available to the on-going programs for children. A major criticism of the administration of the demonstrations and research grants, at present, is the lack of joint planning and integration with the states' programs responsible for the protection of children.

Thank you for your continuing efforts on behalf of children and for this opportunity to testify on the possible extension of P.L. 93-247. I am hopeful that it may yet become an instrument for upgrading the programs of public welfare agencies serving children.

Sincerely,

Jerome A. Lackner, M.D.
Director of Health

The American Humane Association

5351 S Roslyn Street
Englewood, Colorado 80110
303 779 1400

AMERICAN HUMANE

April 8, 1977

Honorable Allen Cranston
U. S. Senate
Chairman Subcommittee on Child and Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Cranston:

We respectfully submit the following statement as testimony for the record in the hearings on the extension of The Child Abuse Prevention and Treatment Act.

We urge that congress reaffirm its concern for the plight of our country's neglected and abused children by reauthorization of Public Law 93-247. However, we strongly recommend that the act be re-focused to maximize support and funding of treatment services to children in identified cases of neglect and abuse.

In its current form major emphasis of the act is to underwrite research and demonstrations with minimal support given to the strengthening of Child Protective Services. We suggest a turn-about in emphasis. More specifically:

1. We urge that 70% of the total sum appropriated under this act be allocated for distribution to the states for the specific purpose of aiding states in developing, strengthening and carrying out child abuse prevention and treatment programs.

2. We recommend relaxation of the rigid criteria which currently bar some states from qualifying for a share in the current (5 - 20%) allocation for this purpose. While supporting the validity of the standards we reject the rigidity with which they are applied. It would more adequately serve those children who desperately need treatment if criteria were relaxed sufficiently to permit substantial compliance with standards.

3. We suggest that there be an allocation of not less than 25% of the appropriation under this act for any fiscal year to be used for grants to institutions of higher learning or to private, non-profit organizations for the conduct of training and/or research in the operation of resource centers and demonstration projects.

Strong emphasis is placed on the recommendation that this allocation be used for grants, not contracts, and that eligibility be focused on non-profit organizations.

4. A major recommendation relates to the composition and function of the Advisory Board:

We urge that the Secretary appoint an Advisory Board composed of 21 persons to advise and assist in coordinating programs of the National Center on Child Abuse and Neglect, and to advise and assist in the development of Federal guidelines for child abuse prevention and treatment programs.

But, we urge a modification in the composition of the Advisory Board from the present pattern.

We recommend that seven members be appointed from NCCAN-funded projects, seven from other knowledgeable persons in the field and seven to be drawn from appropriate federal agencies.

Membership on the Board should extend for the life of the act, but in no event for a period longer than three years. The Board should meet quarterly and should prepare an annual report for the secretary.

It is recommended that not less than 1/2 of one percent, but not more than one percent, of the appropriation for any fiscal year shall be allocated for use in support of the activities of the Advisory Board.

5. The failure on the part of our government to appropriate funds authorized by congress under Title 4B of the Social Security Act for Child Welfare Services has constituted a gross lack of support for services desperately needed to meet the rising demands of an ever expanding problem — the phenomenon of child neglect and abuse.

Our studies have documented not only the mounting tide of incidence of child abuse and neglect (this agency operates the National Clearinghouse on Child Neglect and Abuse), but also the urgent need for more staffing in child protective services and more training for new staff.

For these reasons we urge, also, that consideration be given to using the reauthorization of Public Law 93-247 as a specific for "ear-marking" funds for direct support of Child Protective Service programs at a level consonant with need. An increase of at least ten times the current appropriation could bring that about. Allocation on some formula basis to each state and territory would provide the funds needed to implement state and federal mandates for child protection.

Our national history of response to human needs consistently shows that response is effective only when we specifically earmark funds to meet particular needs, i.e., mental health, retardation, day care, etc.

If congress were to take such a step to help resolve the problem of child neglect and abuse it would bridge the gap between the recognized need and responsibility to protect our nations neglected and abused children and the state's capacity and ability to truly protect them.

(Should this proposal be given consideration the percentage allocations cited in points 1 through 4 would need modification to suit the expanded scale.)

Congress deserves great praise and credit for its concern and willingness to act on this crucial national issue. Public Law 93-247 was a good beginning. It is hoped that the legislation to extend it will take giant strides to improve it!

We strongly urge your support for reauthorization of Public Law 93-247 and pledge you our support in the continuing effort to prevent child abuse and neglect in this country.

Sincerely yours,

Vincent De Francis

Vincent De Francis J.D.
Director
Children's Division

VDF:sc

NATIONAL COUNCIL OF JEWISH WOMEN
15 EAST 26th STREET, NEW YORK, N.Y. [illegible] · (212) [illegible]

ESTHER R. LANDA, NATIONAL PRESIDENT
MARJORIE MERLIN COHEN, EXECUTIVE DIRECTOR

STATEMENT SUBMITTED TO THE SUBCOMMITTEE ON
CHILD AND HUMAN DEVELOPMENT OF THE COMMITTEE
ON HUMAN RESOURCES, UNITED STATES SENATE

APRIL 26, 1977

The National Council of Jewish Women, a social action and community service organization of 100,000 women in Sections across the country, has, since its inception 84 years ago been concerned with the welfare of children and youth. It has been involved in child abuse prevention programs for the last ten years. Our most recent issue of our national magazine Council Woman was devoted exclusively to child abuse. This interest came in part as an extension of our long commitment to comprehensive day care services for children and our more recent concern for juvenile justice. Currently, the National Council of Jewish Women, under the direction of the Task Force on Justice for Children is preparing a Child Abuse and Neglect manual for its Sections and outside groups working in this field. This material will be available for publication early in the fall.

Twenty Sections of the National Council of Jewish Women have sponsored or are now sponsoring child abuse and neglect projects. One such project in Washington D.C., co-sponsored with the Junior League of Washington, is the Family Center, a three pronged approach to the treatment of child abuse. It includes a therapeutic day care center for children 2½ to 6 years of age, parental counseling for the parents or guardians of these children and a twenty four hour hotline to provide immediate telephone counseling and referral information.

WASHINGTON OFFICE, 1346 CONNECTICUT AVENUE, N.W., SUITE [illegible], WASHINGTON, D.C. [illegible] · (202) [illegible]

Our Section in Memphis, Tennessee informs us that the situation in Memphis has been made more evident by a recent case tried there on the death of a 4 year old child (girl) after torture by her parents. This horrendous event sparked an awareness and deep concern over a subject which has received some consistent effort and interest by both the Tennessee Dept. of Human Services, (the public welfare division) and private groups. The girl and siblings had been removed from their home three years earlier and had recently been returned. Additional funds to help provide enough protective service workers might have saved the child's life. Another problem in Tennessee is the concentration in the cities of whatever child abuse services are available when increasing needs are appearing in the rural areas.

The legislation formerly enacted and funded by Congress has provided Tennessee with additional emergency service workers, homemakers and temporary health aides in homes where abused children have been discovered. A continued unmet need is additional foster homes, and group homes for emotionally damaged victims of child abuse. There are presently no more than two (2) such locations in North East Shelby County for such care. Any additional funding which Congress can appropriate for such uses would be greatly needed and used immediately. Prevention services, such as classes in parenting, crisis lines, group counseling and such services now provided by Mental Health Centers and the Protective Services of Tennessee, Department of Human Services would be much needed and expanded by additional funding.

The Tennessee Section lends its endorsement and that of its "overworked Protective Services personnel" in urging Congress to extend the Act and offer appropriations to permit expanded services.

From the work of various Council members in their child abuse programs come the following recommendations. Prevention services, such as classes in parenting, crisis lines and group counseling should be provided by state and city mental health and human services departments and could be started or expanded by additional funds. The families served in the Washington, D.C. Council-sponsored program have lacked knowledge on child development and how to parent no matter what their socio-economic level. Many jurisdictions report a need for additional foster homes and group homes for emotionally damaged victims of child abuse. Any additional funding which Congress could appropriate for such uses would be greatly needed.

We urge your Committee to report legislation which will not only extend the Act, but offer sufficient funds to meet the crying need for assistance to states to provide urgently needed services.

YORK-POQUOSON
SOCIAL SERVICES
DRAWER 917 ● GRAFTON, VIRGINIA 23692

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Elizabeth H. Copeland
Director
Telephone 898-7204

May 5, 1977

The Honorable William Scott
1227 New Senate Building
Washington, D.C. 20510

Dear Senator Scott:

We respectfully submit the following statement as testimony for the record in the hearings on the extension of The Child Abuse Prevention and Treatment Act.

We urge that Congress reaffirm its concern for the plight of our country's neglected and abused children by reauthorization of Public Law 93-247. However, we strongly recommend that the act be reformed to maximize support and funding of treatment services to children in identified cases of neglect and abuse.

In its current form major emphasis of the act is to underwrite research and demonstrations with minimal support given to the strengthening of Child Protective Services. We suggest a turnabout in emphasis. More specifically:

1. We urge that 70% of the total sum appropriated under this act be allocated for distribution to the states for the specific purpose of aiding states in developing, strengthening and carrying out child abuse prevention and treatment programs.

2. We recommend relaxation of the rigid criteria which currently bar some states from qualifying for a share in the current (5 - 20%) allocation for this purpose. While supporting the validity of the standards we reject the rigidity with which they are applied. It would more adequately serve those children who desperately need treatment if criteria were relaxed sufficiently to permit substantial compliance with standards.

3. We suggest that there be an allocation of not less than 25% of the appropriation under this act for any fiscal year to be used for grants to institutions of higher learning or to private, non-profit organizations for the conduct of training and/or research in the operation of resource centers and demonstration projects.

Strong emphasis is placed on the recommendation that this allocation be used for grants, not contracts, and that eligibility be focused on non-profit organizations.

4. A major recommendation relates to the composition and function of the Advisory Board:

We urge that the Secretary appoint an Advisory Board composed of 21 persons to advise and assist in coordinating programs of the National Center on Child Abuse and Neglect, and to advise and assist in the development of Federal guidelines for child abuse prevention and treatment programs.

But, we urge a modification in the composition of the Advisory Board from the present pattern.

We recommend that seven members be appointed from NCCAN-funded projects, seven from other knowledgeable persons in the field and seven to be drawn from appropriate federal agencies.

Membership on the Board should extend for the life of the act, but in no event for a period longer than three years. The Board should meet quarterly and should prepare an annual report for the secretary.

It is recommended that not less than ¼ of one percent, but not more than one percent, of the appropriation for any fiscal year shall be allocated for use in support of the activities of the Advisory Board.

5. The failure on the part of our government to appropriate funds authorized by Congress under Title 4B of the Social Security Act for Child Welfare Services has constituted a gross lack of support for services desperately needed to meet the rising demands of an ever expanding problem--the phenomenon of child neglect and abuse.

Our studies have documented not only the mounting tide of incidence of child abuse and neglect, but also the urgent need for more staffing in child protective services and more training for new staff.

For these reasons we urge, also, that consideration be given to using the reauthorization of Public Law 93-247 as a specific for "ear-marking" funds for direct support of Child Protective Service programs at a level consonant with need. An increase of at least ten times the current appropriation could bring that about. Allocation on some formula basis to each state and territory would provide the funds needed to implement state and federal mandates for child protection.

Our national history of response to human needs consistently shows that response is effective only when we specifically earmark funds to meet particular needs, i.e., mental health, retardation, day care, etc.

If Congress were to take such a step to help resolve the problem of child neglect and abuse it would bridge the gap between the recognized need and responsibility to protect our nation's neglected and abused children and the state's capacity and ability to truly protect them.

Honorable William Scott
May 5, 1977
page 3

(Should this proposal be given consideration the percentage allocations cited in points 1 through 4 would need modification to suit the expanded scale.)

Congress deserves great praise and credit for its concern and willingness to act on this crucial national issue. Public Law 93-247 was a good beginning. It is hoped that the legislation to extend it will take giant strides to improve it!

We strongly urge your support for reauthorization of Public Law 93-247 and pledge you our support in the continuing effort to prevent child abuse and neglect in this country.

Sincerely,

Elizabeth H. Copland

(Mrs.) Elizabeth H. Copland, RSW
Director

EHC:mo

/cc: Honorable Allen Cranston

H.E.L.P. RESOURCE PROJECT
For Abused and Neglected Children and Their Families
A Program of the Department of Human Resources

1123 North Eutaw Street • Suite 400 • Baltimore, Maryland 21201 • (301) 383-5564

Richard W. Bateman, *Director*
Social Services Administration

Curtis L. Decker
Project Director

April 5, 1977

Honorable Allen Cranston
U. S. Senate
Chairman Subcommittee on Child and Human Development
4230 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Mr. Cranston:

We respectfully submit the following statement as testimony in the record in the hearing on the extension of the Child Abuse Prevention and Treatment Act. As one of the funded programs under Public Law 93-247, we have worked in the area of child abuse and neglect for the last two years. We feel strongly that the programs created under this Act have had tremendous and widespread impact, not only in the area of public awareness, identification and reporting of child abuse and neglect, but also in the beginning of developing coordinated multidisciplinary services for abusing and neglecting families.

We strongly recommend the reauthorization of Public Law 93-247. However, several changes in the Act, we think, would further improve its effectiveness.

1. We recommend the relaxation of the rigid criteria which currently bar some states from qualifying for a share in the current (5-20%) allocation for this purpose. Maryland is presently one of those states not yet meeting those criteria. As a result, we have lost important federal aid for the last three years. It's ironic that the H.E.L.P. Resource Project has worked throughout the State of Maryland trying to improve services and yet money that would have implemented many of our programs has been withheld because of the inability ot get certain pieces of legislation passed. In fact, most of Maryland is presently operating under the criteria set by the federal government. It is unfortunate that a few reluctant counties can cause the State to lose out on desperately needed funds. It would more adequately serve those children who desperately need treatment if criteria were relaxed sufficiently to permit substantial compliance with standards.

2. Funds allocated for research and the operation of resource centers and demonstration projects should be given to institutions of higher learning or to private non-profit organizations.

We strongly recommend that this allocation be used for grants and not contracts.

Thank you for the consideration of our views.

Very truly yours,

Curtis L. Decker

Curtis L. Decker
Project Director

CLD/bl

STATEMENT OF THE COMMITTEE ON THE INFANT AND PRESCHOOL CHILD
OF THE AMERICAN ACADEMY OF PEDIATRICS
SUBMITTED TO THE SUBCOMMITTEE ON CHILD AND HUMAN DEVELOPMENT
OF THE COMMITTEE ON HUMAN RESOURCES
UNITED STATES SENATE
APRIL 14, 1977

ROWLAND L. MINDLIN, M. D., FAAP
CHAIRMAN

The American Academy of Pediatrics has been concerned with child abuse and neglect for many years. The present resurgence in national interest stems from a symposium at our 1961 Annual Meeting when Dr. C. Henry Kempe introduced the term "The Battered Child Syndrome". The Academy's Committee on Infant and Preschool Child published its first statement on child abuse in 1966 and a second one in 1972. With Dr. Ray E. Helfer as consultant, this committee developed an audio-tape self instructional program in the recognition and management of child abuse and neglect in 1973. Also in that year the Academy conducted a descriptive study on nine health-based programs for child abuse and neglect under a contract with DHEW Bureau of Health Services Research and Evaluation. At the present time we are evaluating, under a grant from the National Center on Child Abuse and Neglect, the health component of a multi-disciplinary training curriculum that NCCAN has oommissioned.

The American Academy of Pediatrics strongly supports continued funding and relatively high, independent status for programs addressing the problems of child abuse and neglect. We believe that the experiences of the past three years should be drawn upon to modify the restrictions and improve the strucures created by PL 93-247, and to reorder the priorities implicit in its allocation of funds. For instance, we would make it easier for states to qualify for assistance under the act; we would replace the present Advisory Board with one that would draw upon the national expertise that exists; and we would give major emphasis for grants under the act to agencies and programs providing direct services to abused and neglected children and their families and to the training of multi-disciplinary personnel who serve in those agencies and programs.

Changes such as these, we believe, will take more time to clear through the legislative process than is available before the present authorization for funding expires. Therefore, the American Academy of Pediatrics recommends:

1. Continued funding of the present law for one full fiscal year at the current authorization of $25 million.
2. Comprehensive review of the child abuse and neglect legislation by the present Congress.

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February 23, 1977

Senators Cranston, Hayakawa and Riegle
Subcommittee on Child and Human Relations
Committee on Labor and Public Welfare
United States Senate
Washington, D.C.

Dear Senators,

We are pleased to submit written testimony for the Child Abuse and Neglect Hearings, 1977. As evaluators of twelve federally-funded child abuse and neglect projects* and of other locally sponsored child abuse and neglect programs, we would like to share with your committee some preliminary findings and observations from our recent work.

Generally, we perceive the child abuse and neglect field as being at a stage comparable in program development to many other social and health programs in the 1960's. An important problem has been recognized and has captured the attention of the general public. The need for an immediate response has been accepted. But in spite of strong advocacy statements, it remains true that the field is unsure how best to proceed and whether any of the possible approaches really can succeed in the long run to help solve the problem. Indeed, it does not appear that careful plans have been laid for identifying the range of possible strategies and testing the high priority ones. It is precisely in an emergent field such as child abuse and neglect that the strategy of systematic planning, experimentation, demonstration and evaluation, which so many have argued in retrospect should have been the approach in the 1960's, becomes most appropriate.

We believe that many positive lessons have been learned from the demonstrations we are evaluating, as reported in the following pages. However, our experiences suggest that there are several important gaps in the present child abuse and neglect demonstration programs: a lack of any long term, post-treatment follow-up to assess the impact of services; a lack of attention to strategies of prevention; a lack of emphasis on treating children, and the whole family, rather than just parents; a lack of treatment emphasis on the most severe cases where there are imminent threats to children's survival; and, in general, a desire to create a "program" even before coming to any understanding of the most effective and affordable approaches to coping with or solving the problems that the program is to address. It is not too late for the field to take a more systematic and "planful" approach to the problem, remediating some of the current gaps in the federal program; given the limited resources, we regard this as essential.

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*In addition to our current evaluation of the eleven Joint OCD/SRS Demonstration projects funded in 1974, we conducted a two-year evaluation of the Extended Family Center in San Francisco, an early OCD child abuse demonstration service project.

In the following pages we describe the federal child abuse and neglect demonstration effort we are currently evaluating, present some of our preliminary findings, as well as our current thoughts on how child abuse and neglect services might best be delivered.* We hope these comments will help point the way toward a more organized federal approach to the child abuse and neglect problem in the future.

What are the demonstrations and our evaluation attempting to do?

In May of 1974 the Office of Child Development and Social and Rehabilitation Services, D/HEW, jointly funded eleven three-year child abuse and neglect demonstration service projects**; one month later we were funded by Health Resources Administration, D/HEW, to conduct a three and one-half year formative and summative evaluation of these projects. The purposes of this approximately $4 million demonstration are:

(1) To develop and test innovative and/or effective models for the provision of services to abusers and neglectors;

(2) To develop and test innovative and/or effective models for the provision of services to abused and neglected children;

(3) To develop and test replicable models for coordination of community wide systems providing preventive, detection, and treatment services to deal with child abuse and neglect;

(4) To determine the costs, and cost-effectiveness, of different service strategies.

In order to accomplish these purposes, the projects are housed in several different types of agencies (protective services, hospitals, private social service agencies); they employ different kinds of staff (social workers, psychologists, educators, homemakers, nurses, lay people); they use different mixes of services (individual counseling and therapy, group therapy, parent education classes, lay therapy, therapeutic day care, play therapy, supportive and advocacy services); they serve a range of kinds of cases; and they use a range of different strategies for improving the community systems in which they operate. The appended Case Studies of these projects explain in detail the dimensions of the projects.

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*More detailed statements of our early findings appear in the appended report, "Summary of Findings to Date, November 1976."

**The projects include: The Family Center, Adams County, Colorado; Pro-Child, Arlington, Virginia; The Child Protection Center, Baton Rouge, Louisiana; Child Abuse and Neglect Demonstration Unit, Bayamon, Puerto Rico; Arkansas Child Abuse and Neglect Project, Little Rock, Arkansas; Family Care Center, Los Angeles, California; Child Development Center, Neah Bay, Washington; Family Resource Center, St. Louis, Missouri; PACER, St. Petersburg, Florida; Panel for Family Living, Tacoma, Washington; and the Union County Protective Services Demonstration Project, Union County, New Jersey.

In general, the projects are employing a range of traditional and innovative strategies and as such represent pioneering efforts in the field, now being replicated by other communities across the country. It is too early, however, to assess the true impact and importance of the projects; since they have one more year to run, not all the data on their activities have been collected and analyzed. Yet, based on their first two years of experience, preliminary observations and impressions can be presented.

What problems did the projects encounter in implementing these programs?

The projects have encountered many similar problems in implementing their programs, as outlined in detail in the Epilogue of the appended Case Studies Report. The most pressing problems included finding experienced staff members and training them, establishing credibility in the community, establishing working relationships with other agencies in the community, defining what kinds of cases were to be served, and establishing realistic, achievable goals. Because these projects were the first wave of demonstrations, they had very little in the way of experiences of others to rely on; most things they did had to be learned through trial and error. The average time taken to fully implement their programs was close to nine months. Many things can be learned from their experiences to help other projects, as documented in the appended Handbook for Implementing Child Abuse and Neglect Programs. Perhaps the single most important lesson is that new projects must, from the very start, involve all key community agencies in their planning and program implementation. From the federal perspective, this implies that federal agencies should require that proposals for service money demonstrate that community agencies have commitment to and plan to work with the new project. Once a program is underway, coordination with other agencies should be formalized, typically through written contracts. While this takes a lot of time, it ensures that as individual workers turnover, the coordination activities will continue.

How many families do the projects serve and how much does it cost?

The projects intensively serve in total approximately 850 families at any time, with approximately 1200 families served in any one year. In addition, investigations and initial diagnoses are performed for another approximately 800 families a year. The families served do not differ on any significant dimensions from those reported by state Protective Service Departments on the National Reporting Form to the American Humane Association, we expect that these families are also similar to those served by the newer NCCAN demonstration projects. The average cost of serving a family across projects is approximately $1600 per year (families may receive services from two months to two years). Projects primarily using volunteer lay therapists for treatment provision with a focus on the parents spend approximately $1000 per year on a family; projects offering a wide array of services to both parents and children through the use of paid professionals spend approximately $4500 per year on a family. We do not know at this point if the dollar expenditure per family is related to positive outcomes of treatment.

Who are the projects serving and not serving?

In general the projects are serving parents who have physically and emotionally abused and neglected their children, as well as potential abusers and neglectors, from a range of age, income, race/ethnicity, and educational backgrounds. Of these, because of the large number of families needing service related to their treatment capacity, they tend to concentrate on the more motivated cases rather than giving priority to more severe cases in terms of past harm or risk to child or need for intensive service. They tend not to serve extreme psycho-neurotic cases, cases complicated by drug and alcohol abuse, or sexual abusers, but they do refer these cases elsewhere for treatment. They tend not to focus on families with adolescent children who have been abused or neglected. They tend not to focus on the male abuser or neglector. And finally, they tend not to provide treatment services to the abused or neglected child.

Have changes occurred in the projects' communities since the projects' inception?

The child abuse and neglect systems in all eleven communities have undergone significant changes since the projects were initiated. The amount and type of services available and the awareness and education of both professionals and community people have increased dramatically. In general, the key agencies in these communities (protective services, the courts, the hospitals, the police, the schools) are communicating with each other better and coordinating more of their activities. In each community it is apparent that the demonstration project was influential in helping bring about these changes. At the same time, in several communities, other child abuse and neglect activities, prompted by the 1974 Child Abuse and Neglect Act and the subsequent influx of money into the field, were as, if not more, responsible for some of these changes. In any case, we believe that the goal of helping to improve the community-wide system is an important one for any demonstration service project to have.

How successful have the projects been in accomplishing their goals?

With the exception of two projects, one of which has had excessive staff turnover and thus major setbacks in the second year, and one which has had tremendous difficulty implementing the planned program, significant advances have been made in accomplishing the goals the projects have established for themselves (the goals, listed in the appended Case Studies, included such activities as enhancing the communities' awareness of abuse and neglect and establishing an effective treatment center for parents and children). Despite the fact that four of the projects floundered considerably in their first years, their second year activities suggest that their accomplishment of the goals they set will be comparable to projects which got underway with less difficulty.

Do the projects meet the identified need for services in their communities?

While only three of the projects were set up to handle all identified cases of child abuse and neglect in their communities, all of the projects have made significant contributions toward ensuring that the services needed in their communities for identified cases are available. In some instances the projects have developed the necessary services themselves; in other instances, the projects, backed by a growing concern about child abuse in their communities due to the passage of the Child Abuse and Neglect Act and an influx of money into the field, have served as catalysts for the development of the needed services. While none of the eleven communities are fully equipped to handle all of the identified cases, they are much more prepared now than two years ago. Most clients (on the order of 75%) identified in need of services by the community probably now get into the system and obtain some service. Whether the amount, quality, and kind of service these families are getting is adequate for their needs is unknown, but we would readily judge that even in these communities, more services are needed simply to deal successfully with the families currently in the system. How many families with an actual need for service fail to be identified by the community is also unknown.

Were the projects worthwhile investments?

The projects have had important impacts in their own communities and have demonstrated strategies and approaches which, while innovative at the time the projects started, are now widely being adopted around the country. However, the value of a "demonstration project" is not simply its local community impact, but in how much is learned that is useful to other communities. The fact that these projects were funded with a common strong evaluation component from the outset provides a much greater opportunity for learning from the projects' experiences, than has been afforded by demonstration programs in other social problem areas. In the 1960's, millions were spent on "demonstrations" which were never evaluated or were evaluated one-by-one, rather than with a single design. As a result, little was learned, what was learned was not widely shared, and eventual frustration emerged as taxpayers, professionals, and clients recognized that many of the social problems addressed by programs were not being solved on a national basis (and perhaps were unsolvable). It is as important to know if the projects are failing as it is to know if they are succeeding. It is important to know not only if projects succeeded in implementing ongoing provision of service, but if the immediate outcomes of services for families are positive and desirable. It is also important to know what kinds of intervention strategies offer the greater prospects of success and at what costs in designing any kind of state or national policy or program for intervention. The joint demonstrations should provide important insight into such questions. If this happens, the public investment in the projects as "demonstrations" will have been very worthwhile. However, the absence of any long-term follow-up as part of the Federal evaluation does mean that the question of whether the projects really "solved" the child abuse/neglect problems in the families they served will remain unanswered.

What will happen to these projects when federal funds end?

An inherent problem with all demonstration projects is that the end of the demonstration period heralds the end of financial support and projects stand a good chance of disappearing. The strength of a demonstration lies not only in its ability to test out meaningful strategies, but also to perpetuate its existance, if the demonstration was in fact valuable. It appears that certain components of all the projects and all components of some will be picked up by local community agencies, so that, in principle, the projects' activities will continue. This is clearly a statement of confidence by communities in the value of the demonstrations.

What services appear to be important?

It appears, and workers in the eleven projects agree, that individual counseling is not sufficient by itself as a service to families with abuse and neglect problems. Abusive and neglectful actions are symptoms of a wide range of complex emotional, situational and behavioral issues that simply cannot be dealt with simplistically. Services to complement individual counseling, which are thought to be very important, include: group treatment including self-help groups such as Parents Anonymous; parent education classes; lay therapy; and day care. In addition, basic advocacy and supportive services such as welfare and housing assistance or transportation appear to be essential. Regardless of the mix of services provided and who provides them, it appears very important, from the perspective of quality case handling, that qualified, experienced people be used in a supervisory capacity to help workers with the most severe cases and to ensure that workers periodically review and continually maintain awareness of all their cases -- this is particularly true for projects that use lay or inexperienced workers for treatment provision.

Are formal federal guidelines for the delivery of quality services needed or desirable?

We do not believe that there should be federal guidelines for the delivery of quality services at this time; the complexity of the problem suggests that flexibility is important. There seems to be emerging professional agreement on what the critical elements of quality case management and service provision are for different kinds of cases, but "best practice" consensus is by no means imminent and should not be legislated at this point, if ever. However, the federal government could play a major role in ensuring that the experiences with treatment delivery of those in the field are documented and distributed widely. Child abuse and neglect have been recognized as important problems, and the need to respond has been accepted, but no one really knows for sure what works. A response of experimentation and evaluation seems most appropriate for treatment, although the need remains critical to provide protection for children in immediate risk of severe harm.

What is the value of an interdisciplinary approach to treatment?

Our impression is that the greatest value of an interdisciplinary approach to treatment is in training and sensitizing workers to the range of problems their families might have and in pursuing a range of alternative treatment approaches. It does not appear to be important for the client to have direct interactions with people of different disciplinary backgrounds, although different disciplinary perspectives are necessary to understand the clients' needs. In addition, an interdisciplinary approach can have great value in improving the cohesion of the community-wide child abuse and neglect system as well as the coordination of any given case. The concept of an interdisciplinary approach should not be limited to the use of a Multidisciplinary Diagnostic Team and need not be conceived of as a static group of people; there appears to be great value in involving many different individuals and agencies in a project's treatment efforts.

What has been learned about the use of non-professionally trained workers?

It appears that the use of non-professionally trained workers, provided they have adequate supervision, is very do-able, and because of cost savings, particularly worth further trial in communities with limited resources. Non-professionally trained workers appear to be a good complement to and possible substitute for professional workers, particularly in working with less severe cases. In general, we are very encouraged by what we see in those projects using lay therapists and other types of volunteers.

What kinds of training are needed by those who work with abusive and neglectful families?

Individuals who will work with abusive and neglectful families clearly need training in the dynamics of abuse and neglect, including sexual abuse and related issues. While coursework training may be of value, it appears that training on the job, from supervisors, an interdisciplinary team, consultants and fellow workers is much more important. Workers in projects which lack this ongoing in-house training by many different individuals appear to have a more difficult time serving clients.

Is it possible to prevent the reoccurrence of abuse and neglect?

Most of the families whose cases have been closed by the demonstration projects to date have exhibited improvement in family functioning and propensity for future child abuse and neglect. However, only a small fraction of the cases served have completed treatment so far. A valid conclusion about the outcome for families of the services provided by the projects must thus await the completion of the demonstrations and the analysis of client data. Those few studies in the child abuse/neglect field which have conducted follow-up after treatment have shown, however, that a high proportion of families receiving treatment experience some reoccurrence or at least the need for subsequent intervention and support of family functioning.

For example, the University of Pannsylvania School of Social Work, in one of the largest follow-up studies, found that of all cases previously served in the early 1960's for abuse and neglect by the Philadelphia Society to Protect Children, close to 60% returned again for service within five years after termination of the agency's service, and many returned three, four or even more times. Neglect, in particular, was judged a chronic condition. These earlier studies often focused on more difficult and disadvantaged families than are currently being identified and treated in community service systems, but it seems clear that we can never expect a 100% success rate and perhaps not even a high long-term success rate for some kinds of families.

We and the demonstration projects maintain a belief, however, that a significant amount of reincidence can be avoided for many families, and particularly those experiencing abuse. We do not yet have sufficient data collected to test this, nor has OCD currently provided for post-treatment follow-up on the clients served in the demonstration projects we are evaluating. There are OCD plans for a short-term follow-up study of families in other demonstrations. Generally, however, there is a critical need for some long term (5-10 year) follow-up study to know better if treatment services do help curb abusive and neglectful behavior by parents.

Can services be effective in helping the child recover from the effects of abuse and neglect?

Our studies have shown that abused and neglected children improve substantially in certain developmental areas, particularly motor skills and socialization behaviors, during the time they are in specialized day care or therapeutic day care programs. In general, the children studied were those whose parents were receiving services from the same program. We do not know if the psychological and emotional scars of the abuse or neglect are lessened as a result of treatment. Since there is a much higher rate of child abuse/neglect among parents who were themselves abused or neglected as children, the successful treatment of emotional scars is critical in any long-term prevention strategy. Once again, the field greatly needs a long-term (in the case of children, 20-25 years) follow-up study to determine both the long term impacts of abuse and neglect as well as the long term effects of treatment.

Based on the projects' experiences, where should child abuse and neglect programs be housed?

It is very clear that protective services is the most appropriate agency to be the focal point of child abuse and neglect systems to receive and investigate reports and to provide ongoing case management and some treatment. However, child abuse and neglect treatment should not be restricted to protective service departments, and in fact, protective services should work closely with many other agencies in the community, not only in investigations, but in delivering treatment services. It is important that protective service agencies keep individual workers' caseloads small so that clients actually get services and do not simply remain names in case records. Protective service agencies should also, where possible, place the treatment program outside the edifices of the parent agency, in other words create an atmosphere for a program which is informal and non-stigmatizing, in essence where desks and chairs and replaced by sofas. This seems to be very important in helping clients be more receptive to services. Finally, to strengthen the local community system, particularly the protective services department, it appears important for state protective service agencies to take an active role in child abuse and neglect matters, primarily by establishing formal linkages with other agencies within the Human Resources area at the state level.

Do we need more demonstration projects and more related research?

While many things will be learned from the current sets of demonstrations, we believe that there will be great value in continuing to fund child abuse and neglect demonstration projects for at least three more years. The current sets of projects are not testing out all the possible interesting strategies for working on abuse and neglect problems. Within the set of demonstrations, there are few efforts to work directly with the abused or neglected child and few preventive efforts outside of working with identified cases. In addition, few of the projects are focusing on any particular type of client but rather are serving mixes such as potential and actual cases of widely varying severity, which greatly diffuses their efforts, and few of the projects are doing any systematic follow-up on the cases they are serving. Should NCCAN continue to fund demonstration program efforts, we would hope to see more projects working in these areas.

Of utmost importance is the continuation of research and evaluation of demonstration projects. The projects themselves, because of the pressures of their work, have not been successful at doing their own research and evaluation; this needs to be done by an outside group. Unless this is done, the experiences and lessons learned by the projects will go unrecorded and we will find ourselves repeating the mistakes of other social programs. Many millions of dollars will be spent on demonstrations producing little learned wisdom that is shared widely. Research and evaluation of demonstrations must go beyond descriptive, or what some refer to as formative, studies. The payoff of a demonstration program is in understanding the outcomes or impacts of alternative strategies -- as well as the costs -- so that program and policy makers can make choices between alternatives. Thus, "summative" or outcome evaluations must be included as part of a demonstration strategy.

Do we need a categorical program for child abuse and neglect?

Because child abuse and neglect are symptoms of so many other problems handled by ongoing family and child-related social service and health programs, we believe that in the long run there will be no need for, and in fact there should not be, a special categorical program for child abuse and neglect. However, there is still a great deal to learn about child abuse and neglect before the problem can be prevented or families with these problems can effectively be served by social service and health programs in general. We feel very strongly that specific child abuse and neglect programs must be continued for the next several years with an eye to eventually merging them with other social service and health programs.

We hope that these preliminary findings and observations will be of value to you and your committee as you deliberate the merits of renewing the child abuse and neglect legislation and determine what changes, if any, should be made in that legislation. Should you have any additional questions to ask about our findings, we would be pleased to respond.

Anne Harris Cohn, DPH, Project Director
Frederick C. Collignon, Ph.D., Principal
  Investigator
National Child Abuse and Neglect
  Evaluation

AHC/FCC:dg
Enclosures: Case Studies
            Handbook
            Summary of Findings, November 1976

Testimony on The Child Abuse Prevention and Treatment Act (PL. 93-247)

prepared for

The House Subcommittee on Select Education

by

Kathleen Lyons, Washington Representative

National Coalition for Children's Justice

March 1977

The National Coalition for Children's Justice is a private, non-profit organization working to improve conditions for institutionalized youngsters and children in public care in general. The Coalition is grateful for the opportunity to comment on the renewal of PL. 93-247, The Child Abuse Prevention and Treatment Act.

Coalition members have carefully monitored implementation of the Act since its passage in 1974. It is our reluctant conclusion that continuation of the majority of activities authorized under PL. 93-247 cannot be justified in financial or human terms; and, that maltreated children and their families would be far better served by integrating the positive features of the Act into more comprehensive child and family services legislation. For this reason, the Coalition supports the Administration request to limit reauthorization to a one-year period with the understanding that this time will be used by Congress and DHEW to formulate a broad federal response to the needs of abused, neglected children. New policy in this area should address a number of issues that lie outside PL. 93-247's present mandate or capability, including: 1) ways to encourage the development of preventive and crisis-oriented services for troubled families at the local level; 2) establishment of methods to keep track of children in public care and to ensure their timely return to a secure family-like environment; and, 3) the development of monitoring mechanisms for measuring the effectiveness of service providers and for guaranteeing their fiscal accountability.

Congress may want to consider amending PL. 93-247 in ways which will help guide the Federal government in mapping out a national strategy to protect children. This Subcommittee has heard ample testimony describing the poor adminstration of National Center on Child Abuse and Neglect (NCCAN) programs, and has received a number of suggestions for improving various portions of the Act. Chief beneficiaries of the modest research and demonstration program authorized under PL. 93-247 have not been abused, neglected children nor even direct service providers but rather academicians, researchers, and private, profit-making consulting firms. NCCAN has supported research of limited utility such as the multimillion dollar incidence study and inquiries aimed at identifying "high risk" candidates for abusive parenting. Representatives of the poor and minority groups have expressed understandable concern over NCCAN-supported research efforts that associate abusive behavior with their constituencies, particularly in cases where adults are labelled as potential abusers even before they become parents. In addition to funding a number of questionable research projects, NCCAN has also wasted money on training and technical assistance activities that duplicate efforts undertaken earlier by other federal agencies. In deciding what programs to fund, NCCAN, for the most part, has not made use of the wealth of experience and practical knowledge built up over the years by direct service providers. For these reasons the Coalition endorses amendments to PL. 93-247 earmarking more funds for services and less for research. In addition, service providers themselves should be encouraged, whenever feasible, to add research and evaluation components to their own projects.

The Coalition also supports a proposal by the National Committee for the Prevention of Child Abuse to permit states with less inclusive mandatory reporting statutes to receive federal funding under the Act. Since passage of this legislation, public awareness and reporting of suspected incidents of abuse and neglect have increased dramatically; services for troubled families, unfortunately, have not kept pace. The majority of protective services units around the country have neither the staff nor the funds to operate effective rehabilitative programs for abusive families that are already known to them. NCCAN's promotion of broadly conceived state mandatory reporting laws, including such hard to define behavior as "emotional abuse," in these circumstances is unconscionable. This one-sided emphasis on reporting in the absence of generally available services places "helping" agencies in the position of unwillingly abetting a continuation of the abusive cycle. Young victims of maltreatment in the home are subjected to unsettling dislocations in foster care and are "high-risk" candidates for additional abuse in residential child care institutions. The Government Accounting Office recently reported that millions of dollars have been paid by DHEW to child-care institutions which did not even meet notoriously lax state licensing standards. "Almost half of the institutions we visited were either unlicensed or had serious physical deficiencies."[1] To discourage improper placement of abused/neglected children in warehousing settings or in an unending series of foster homes, the Coalition proposes that new language be added to Section 4(b)(2) of the Act authorizing grants to states:

> (K) Require court approval of a written treatment plan for every child removed from the home for reasons of neglect or abuse which would include: 1) where the child will be placed; 2) what steps will be taken by

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[1] GAO Report, "Children in Foster Care Institutions - Steps Government Can Take to Improve Their Care," JRD-77-[illegible], Feb.22, 1977.

> the agency charged with his/her care for returning the child home; and 3) a timetable for insuring the child a safe and permanent home either through return to his/her biological parents (or legal caretakers) or through initiation of termination of parental rights proceedings. The plan shall insure that, in general, placement will be in foster family or small group home within the child's own community unless the placement agency submits proof, in the form of recent overt behavior, that the child is a danger to him/herself or others and requires institutionalization. At no time shall any child removed from the home for reasons of abuse or neglect be placed in a correctional setting.
>
> (L) Provide for a review of the status of all children removed from the home for reasons of abuse or neglect, including voluntary placements, by the court or an alternative body approved by the court at intervals not to exceed six months.

There appears to be no relationship between a state's participation under the Act and the effectiveness of its prevention and treatment program; furthermore a great deal of time and effort has been needlessly wasted by NCCAN and state officials in futile arguments over whether or not a state qualifies for funding under Section 4(b)(2). If Congress decides to allocate a greater percentage of funds available under the Act to the states, the Coalition recommends that all states be allowed to participate and that the qualifiers laid out in Section 4(b)(2), with the addition of the amendments cited above, no longer be conditions for participation but goals toward which all state protective services should work utilizing funds newly available under the Act. Although the money flowing to the states under this program would be miniscule compared to the magnitude of the problem, this approach would at least give states an idea of the direction which future Federal initiatives are likely to take and would be infinitely fairer than NCCAN's present system of doling out funds.

One final word of caution. The immediate needs and individual circumstances of abused children and their families are many and complex. Policy to deal with this problem must take into account much more than reporting requirements and incidence rates in order to be effective. An entire spectrum of concerns needs to be addressed in a comprehensive fashion similar to that adopted by the Juvenile Justice Standards Project. In addition to prevention and treatment resources, "gateway" laws and procedures that define the kind and quantity of children entering the public care system and "exit" mechanisms such as termination of parental rights laws and subsidized adoption must be taken into account. Only by looking at the system as a whole can policies be developed that will adequately protect the health and well-being of our nation's young people.

II.—ADDITIONAL COMMUNICATIONS

The City of New York

HUMAN RESOURCES ADMINISTRATION
DEPARTMENT OF SOCIAL SERVICES
SPECIAL SERVICES FOR CHILDREN
80 LAFAYETTE STREET, NEW YORK, N.Y. 10013

Carol J. Parry, *Assistant Commissioner*

April 25, 1977

Honorable Alan Cranston
United State Senator
Committee on Labor and
 Public Welfare
Washington, D.C. 20510

Dear Senator Cranston:

I wish to respond directly to the series of questions relating to child abuse legislation which you provided at the time of my testimony in Washington on April 6th. Although my prepared statement did relate to many of the questions you have raised, I do wish to take this opportunity to comment more directly to your specific queries.

Existant Models of Service

In our view, there have been many programs which have demonstrated effectiveness in the treatment and rehabilitation of abused and neglected children and their families. The treatment approach first developed in Denver by Dr. C. Henry Kempe and his associates has proven to be instrumental in child abuse prevention, in strengthening and preserving families and in maintaining children within their own homes. In your own home State of California, Henry Giarretto has reported success in the treatment of child sexual abuse, a serious problem of substantial dimension across the country.

In New York, an intensive in-patient treatment program at the New York Foundling Hospital Parent and Child Center under the direction of Dr. Vincent Fontana has achieved a relatively high rate of rehabilitation given the multiplicity of problems experienced by patients accepted into the program. Another effective treatment program, centered at the Downstate Medical Center in Brooklyn, New York will soon terminate vitally needed services due primarily to funding difficulties. Other successful treatment programs have been reported and described in the literature.

We strongly believe that the extension of the Child Abuse Prevention and Treatment Act should assure fullest support possible for the continuation, expansion and replication of programs that work, while at the same time encouraging a somewhat more limited opportunity for development of innovative, dynamic and resourseful programming. Interestingly, as noted in my formal testimony, we in New York City's Special Services for Children, in response to an RFP to apply for funds, proposed a demonstration project modeled after the aforementioned Denver program. The project, had it been funded, would have enabled the establishment of a direct treatment service in the Bronx, New York, a borough in which child abuse and maltreatment rates have been high. The proposal was rejected, in part because it was not viewed as being sufficiently innovative.

Research

We certainly recognize that on-going research is essential to a better understanding of the child abuse and neglect problem, and crucial to our efforts to develop new preventive strategies, as well as treatment and interventive techniques and modalities. We nonetheless feel that the primary emphasis and direction of future funding should support direct treatment to already identified children and families in need,utilizing already proven child protective service approaches.

We believe that further research should not be conducted at levels which substantially limit the capacity to support vital direct treatment services. We must report that we have realized very little direct benefit from the millions of dollars thus far devoted to research endeavors, largely due to the absence of any effective mechanism assuring for broad dissemination of new insight and knowledge gained as a result of research efforts.

Future research should be focused on questions, concerns and issues related directly to prevention and treatment as the title of the Act implies, and not for example, to the determination of nationwide prevalence which we believe is a relatively unproductive, and perhaps unfeasible endeavor.

Similarly, inordinate amounts of money have apparently been spent on such other non-direct services as coordination projects, conferences, seminars, institutes etc.

Allocation of Funds

We have noted above that funding priorities should be placed clearly on the continuation, expansion and replication of direct service programs that have demonstrated effectiveness in the prevention and treatment of child abuse and neglect.

To the extent possible, available funding should be apportioned in some relation to the demonstrated prevalence and incidence of reported child abuse and neglect within States and localities. As I noted in my testimony, it is absolutely unconscionable that a large public child welfare agency such as Special Services for Children has yet to receive any direct monies appropriated as a result of the passage of P.L. 93-247. Distribution of money for child protective intervention and treatment should take into account that such service delivery is largely a responsibility of public child welfare agencies in all but perhaps a few states. These agencies have responsibility not only for the provision of direct services, but also for the monitoring and coordination of supplementary and ancillary services. Further, methods should be established to assure that all allocated funds be channeled swiftly to the recipient agency thus preventing long and intolerable delays in the start-up of funded programs. Monies long ago appropriated to Special Services for Children remain tied up in bureaucratic red tape.

While we are hardly in position to comment upon whether the federal government should continue to support specific programs, we do believe that there needs to be close monitoring of funded programs and annual determinations made as to re-funding. This can best be accomplished by expansion of the Advisory Board to include non-governmental members selected on the basis of demonstrated knowledge and expertise in the child abuse area and with assurance that they have no affiliation to funded programs or with agencies seeking funds. In addition, we believe that the operation of the National Center should be subject to systematic monitoring and intensive Congressional oversight as to the application and administration of the legislation. In this regard, we recommend extension of the Act for a single year only. This would be particularly appropriate when viewed within the context of reorganization of the Children's Bureau.

State Qualification for Formula Grants

New York State is of course one of the thirty States which has already qualified for funding under the formula program in that the ten criteria for eligibility have been met. We support the continuation of such eligibility criteria provided that States now ineligible be given an extended period of time to qualify and that such States be considered for receipt of funding solely for the purpose of strengthening legislation and administrative practises so that they conform to the standards embodied in the Act. We would also recommend finalization of the Model Act and additional financial incentives to those States which strive to incorporate provisions of such a model in local statues.

In this manner, we can help to assure more effective protective service intervention and treatment to children and families in all States. While we recognize the need for individual State variations in legislation, we nonetheless support the establishment of basic, uniform legislative standards.

Training

We view the direct implementation of training programs for child protective service personnel as a local responsibility. However, given our high priority on service delivery, we would welcome federal financial and technical support to training activities. We would recommend that the National Center work to develop training materials, including audio-visual aides, papers, etc. Training guides should be flexible allowing for local modification and should be widely disseminated. Material should be regularly updated and reflective of new knowledge gained as a result of nationwide programming and research activities.

Resourse Centers

In my testimony, I referred at some length to the network of technical assistance and resourse centers serving our region. While I cannot really comment upon the effectiveness of such a structure nationwide, we frankly found the system to be generally unresponsive to local needs for many reasons, not the least of which included their geographic distance from the metropolitan area where well over half the statewide total of reported cases occurred.

Any consideration given to continuation of the resource centers should provide assurance of funding at levels which will permit a greater degree of involvement with and attention to local concerns, problems and issues. Our knowledge of the fine work being accomplished by the Protective Service Resourse Institute (at Rutgers in New Jersey) supports our contention that the network can play an active role in the strengthening of child protective services programming. Regrettably, the Rutger's Resourse Institute serves the entire region exclusive of New York State.

Funding Levels

We support continuation of funding at the same levels as in previous years. We do wish to make two recommendations, however, which would have great impact on the expansion of preventive and protective service programming. Firstly, we strongly urge lifting of the Title XX ceiling, a measure which would enable us to provide a more comprehensive range of quality child welfare services generally, and protective services in particular. Secondly, substantial increases in the appropriation for child welfare services under Title 4B would be an extremely effective mechanism for stimulating the development of vitally needed child welfare programs. Such measures would reflect a federal commitment to protecting the health and welfare of our nation's children to a far greater degree than extension of Public Law 93-247.

I hope that these additional comments which I submit in supplementation to my testimony will be helpful to you. I am sincerely appreciative of your interest and concern.

Very truly yours,

Carol J Parry

Carol J. Parry
Assistant Commissioner

UNIVERSITY OF COLORADO
MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80220

COLORADO GENERAL HOSPITAL
COLORADO PSYCHIATRIC HOSPITAL
CHILDREN'S DIAGNOSTIC CENTER
SCHOOL OF MEDICINE
SCHOOL OF NURSING
SCHOOL OF DENTISTRY

April 11, 1977

Senator Alan Cranston, Chairman
Senator S. I. Hayakawa, Member
Senator Donald W. Riegle, Jr., Member
Subcommittee on Child and Human Development
of the United States Senate
Committee on Human Resources
Washington, D.C. 20510

Dear Senators:

Thank you for your courtesy during the senate hearings on the child abuse prevention treatment act.

REPLY TO QUESTION 1:

Some experts, such as Drs. Ziegler and Gil, maintain that we do not know enough to do anything useful about child abuse without much further fundamental research, done preferably by psychologists and sociologists. I strongly disagree.

After regularly running 50% reabuse rate fifteen years ago, we have not had a child reabused in any of our treatment programs over the past eight years, and we deal with a case a day and five on a weekend at the Denver General Hospital and the Colorado General Hospital. Further, even with out inadequate system, our deaths, which have been steady for 19 years at 20 for Denver and 5 for Adams County have gradually decreased to 0 to 1 each in the past two years.

Research has taught us that case work for the mother alone does not work, but that family problems require family solutions. This means early identification and interdisciplinary approach to family diagnosis and the development of a treatment plan and the availability of additional modalities of treatment such as lay therapists, homemakers, crisis nurseries, therapeutic day care, therapeutic nursery schools, self-help groups such as Parents Anonymous and outreach services for young families through health visitors when families are found to be in need of extra services during labor, delivery and nursery stay in the hospital. Studies at the University of Colorado, Vanderbilt and the University of North Carolina have shown that abuse can be predicted and we have shown that serious abuse can be prevented. Refusal to use existing knowledge to help families simply makes no sense. The principal objection by psychologists to research done by pediatricians is that the work wasn't done by psychologists.

Interdisciplinary child protection teams are now in place in virtually every hospital in the United States, but they do not yet have a proper place in each of our 3,300 county welfare departments except in the state of Colorado where the law mandates a multidisciplinary team for each county having more than 50 reports. Increasingly, throughout the country alliances between medicine, nursing, social work, the police and the courts have been formed as a direct result of the message given to them by this important bill.

THE UNIVERSITY OF COLORADO IS AN EQUAL OPPORTUNITY EMPLOYER

Senators Cranston, Hayakawa and Riegle, Jr.
April 11
Page 2

REPLY TO QUESTION 2:

We should in this bill try to provide support for replicating programs of demonstrated effectiveness. For example, Adams County, Colorado, with a population of 200,000 received a demonstration grant[1] and was able to supplement the basic service of social workers and homemakers with lay therapists, a therapeutic nursery school, therapeutic day care, crisis nursery, a residential family learning center as an alternative to foster care separation, self help groups and the development of an interdisciplinary child protection team with strong community support and excellent relationships to the court. I believe Adams County, despite their recent loss of funds both at the state and the national level is struggling to maintain these services although it is clearly deteriorating. Foster care stay, which used to average three to four months, is now averaging 15 months with cutback in funds. In other words, we have seen the promised land and precisely because a demonstration program is effective, it is terminated in a state with very limited resources.

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[1] See Chapter 15, "Managerial and Financial Aspects of Social Service Programs" in Child Abuse and Neglect: The Family and the Community, Eds. Helfer, R.E. and Kempe, C.H., Ballinger Press, Cambridge, Mass. 1976.

REPLY TO QUESTION 3:

The research dollars expended so are are not of the same quality as those who have gone, through peer review, through the National Institute of Mental Health, for example. Indeed, requests turned down by NIMH have subsequently been funded by OCD. The single biggest question does not lie with improving the definitions of child abuse and neglect. Those of us who see abused children roll in day after day have no problem with definitions (and several of them are stated in our books). What does need answering is:

1) How early intervention can prevent abuse and help families get a better start?

2) How to better give supplemental parenting to children doomed to live in an abusive environment until they grow up.

3) How to get standard nurseries set up to accept these difficult children utilizing newer techniques?

4) How one can overcome the enormous isolation experienced by young families from the moment they leave hospital?

5) How voluntary relinquishment of an unwanted child might be facilitated?

I would not amend the act to change the nature of research but its quality, forming an alliance with NIMH and NICHD and the Office of Education and others who have received research applications in this field. There are actually fewer dollars in HEW for research in child abuse now because of the feeling of all other agencies that only OCD funds should be used.

ANSWER TO QUESTION 4

I have submitted a short and long version of this bill with allocations of funds which I enclose.

ANSWER TO QUESTION 5

I believe the grant should no longer support any incident studies nor production of training materials.

ANSWER TO QUESTION 6 - Prevention of Child Abuse as an emphasis.

I enclose two predictive studies, one of our own and one by Dr. Hunter of the University of North Carolina, for your consideration. A third study from Vanderbilt will reach you shortly.

A. It is possible to prevent child abuse of a serious nature

B. The bill could bring about emphasis on preventive practices by encouraging outreach services following delivery, of families thought to be in "need of extra services" in the best judgment of the physicians and nurses. Let me add that these non-invasive, routine observations are becoming part of good obstetric and pedicatric care on many maternity services, but there are no funds now for the establishment of health visitor systems.

ANSWER TO QUESTION 7:

As a director of a resource center, my answer is clearly biased by what we believe we have been able to accomplish in the states of Colorado, Utah, Montana, Wyoming, North Dakota and South Dakota. Resource centers should not only exist, but their staff should become the good right arm of the NCCAN who complain of being understaffed but do not utilize a tremendous amount of human talent and skill in the regional resource centers.

ANSWER TO QUESTION 8

I believe all states should now be qualified for funding by the changing of wording proposed in our support legislation. One reason for this is that all states are on the right path and simply changing a state law to comply does not in any way assure changes in practice. For example, Hawaii quickly added "emotionally abused" to their legislation but not a single case has been brought since this change has been made, while Colorado, which feels that emotional abuse is adequately covered under the phrase, "failure to provide reasonable care and protection," has brought a significant number of cases successfully to judicial intervention.

ANSWER TO QUESTION 10:

The in-house advisory board has been a disaster, and is attended by fourth and fifth level personnel. None of the top people either at NIMH or NICD go near it. It was created on the insistence of Secretary Weinberger who substituted this for the congressionally proposed advisory board of 15 member representatives of the nation at large which would be similar in nature to the NIH Councils to the Institute of Health, Institutes which have worked so well for thirty years.

ANSWER TO QUESTION 11

I believe the act should be extended for 3 to 4 years. I cannot see how anyone who receives research support can engage in the kind of long term effort needed on a year to year basis. Research staff is trained slowly and cannot be kept, I feel, with a one year extension. No new grants can be safely given under one year authority, and no one can hire staff with a good conscience on a one year authorization.

Secondly, while I understand the administration's desire to reorganize family services, the appointments made so far in the child health field have not inspired any of us with confidence that effective and strong leadership and highest competence will be effectively brought to bear on the issue of child abuse and neglect. Imperfectly though the act has been administered, we believe we can make many required changes through administrative persuasion while a one year extension may lead to loss in research and, conceivably, loss of the whole effort.

I believe the dollar authorization should be doubled to impact on the grass roots efforts of significant numbers of the 3,300 child protective service departments serving our counties. If even half received some funds, after due compliance with the revised act I have proposed in our major revision, the other half would follow through community pressures.

Respectfully submitted,

C H Kempe

C. Henry Kempe, M.D.
Professor of Pediatrics
and Microbiology

Director, National Center
for Prevention and Treatment
of Child Abuse and Neglect

CHK:mc
Enc

Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act".

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall--

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect;

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect;

(3) ~~compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;~~

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) ~~make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.~~

(c) The Secretary may carry out his functions under subsection (b) of this section either directly or by way of grant or contract."

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

MINIMUM VERSION

December 1976

PROPOSED AMENDMENTS

conducted, currently conducted research AND PROPOSED research

(3) DISSEMINATE COMPLETED TRAINING MATERIALS FOR PERSONNEL WHO ARE ENGAGED OR INTEND TO ENGAGE IN THE PREVENTION, IDENTIFICATION OR TREATMENT OF CHILD ABUSE AND NEGLECT.

. . ."child abuse and neglect" SHOULD INCLUDE THE ELEMENTS OF

DEMONSTRATION PROGRAMS AND PROJECTS	**PROPOSED AMENDMENTS**
SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for ~~demonstration~~ programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be—	
(1) for the ~~development and establishment of~~ training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect;	(1) for the FUNDING of training programs for . . .
(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, ~~including direct support and supervision of satellite centers and attention homes~~, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;	. . .such services; AT LEAST ONE NON-FEDERAL CENTER TO BE KNOWN AS A REGIONAL RESOURCE CENTER SHALL BE ESTABLISHED AND MAINTAINED IN EACH OF THE TEN DEPARTMENTS OF HEALTH, EDUCATION AND WELFARE REGIONS. THE SECRETARY SHALL ESTABLISH MINIMAL STANDARDS OF STAFF EXPERIENCE IN DIRECT SERVICES AND RESEARCH IN THE AREA OF CHILD ABUSE AND NEGLECT, AVAILABILITY OF DIRECT SERVICES, PREPARATION FOR EXPERT CASE CONSULTATION IN THE AREA OF CHILD ABUSE AND NEGLECT, AND OTHER IMPORTANT RESOURCES FOR PROJECTS FUNDED UNDER THIS SECTION.
(3) for furnishing services of teams of professional and paraprofessional personnel which are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and	
(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.	
Not less than 50 per centum of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.	
(b) (1) Of the sums appropriated under this Act for any fiscal year, not less than ~~5 per centum and not more than 20~~ per centum may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.	than 60 per centum may be used by the . . .

(2) In order for a State to qualify for assistance under this subsection, such State ~~shall~~—

[illegible]

States SHOULD --

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting;

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation ~~shall be~~ initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps ~~shall be~~ taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians;

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the date of ~~enactment~~ of this Act, appoint an Advisory Board on Child Abuse and Neglect ~~(hereinafter~~ referred to as the "Advisory Board"), which shall be composed ~~of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.~~

(b) ~~The Advisory Board shall prepare and submit, within eighteen months after the date of enactment of this Act, to the President and to the Congress a report on the programs assisted under this Act and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.~~

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or ~~$1,000,000~~, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

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*Amendments Section 2(c) and Section 4(c) added by P.L. 93-644, approved January 4, 1975.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 93-[illegible] (Comm. on Education and Labor).
SENATE REPORT No. 93-[illegible] (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
[illegible] considered and passed Senate.
Dec. [illegible] considered and passed House, amended.
Dec. [illegible] Senate agreed to House amendments with amendments.
Dec. [illegible] House concurred in Senate amendments.

PROPOSED AMENDMENTS

SEC. 6. (a) The Secretary shall, within sixty days after the date of THIS AMENDMENT TO THE "CHILD ABUSE PREVENTION AND TREATMENT ACT," APPOINT AN ADVISORY BOARD ON CHILD ABUSE AND NEGLECT (HEREINAFTER REFERRED TO AS THE "ADVISORY BOARD"), which SHALL be composed of 15 MEMBERS REPRESENTATIVE OF THE NATION AT LARGE, REPRESENTATIVE OF EXPERTISE WITHIN THE SUBSTANTIVE AREA OF CHILD ABUSE AND NEGLECT, AND REPRESENTATIVE OF THE RELEVANT PROFESSIONS INCLUDING BUT NOT LIMITED TO MEDICINE, PSYCHIATRY, LAW, SOCIAL WORK, AND PSYCHOLOGY, THE TERMS OF 5 MEMBERS TO EXPIRE TWO YEARS AFTER APPOINTMENT, THE TERMS OF 5 MEMBERS TO EXPIRE FOUR YEARS AFTER APPOINTMENT, AND THE TERMS OF 5 MEMBERS TO EXPIRE SIX YEARS AFTER APPOINTMENT, WITH SUBSEQUENT APPOINTMENTS TO BE FOR A PERIOD OF 6 YEARS EACH.

(b) No more than one-third of the members of the Advisory Board shall be from organizations federally-funded.

(c) . . . .or $475,000, whichever is the lesser. . . .

ALTERNATIVE VERSION March 1977

PROPOSED AMENDMENTS

Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act".

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall--

(1) compile, analyze, and publish a summary annually of recently ~~conducted and currently~~ conducted research on child abuse and neglect;

conducted, currently conducted research AND PROPOSED research

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect;

(3) ~~compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;~~

(3) DISSEMINATE COMPLETED TRAINING MATERIALS FOR PERSONNEL WHO ARE ENGAGED OR INTEND TO ENGAGE IN THE PREVENTION, IDENTIFICATION OR TREATMENT OF CHILD ABUSE AND NEGLECT.

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) ~~make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.~~

(c) The Secretary may carry out his functions under subsection (b) of this section either directly or by way of grant or contract.*

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

. . ."child abuse and neglect" SHOULD INCLUDE THE ELEMENTS OF

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be—

(1) for the ~~development and establishment~~ of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect, and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect;

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel which are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Not ~~less than 50 per centum~~ of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.

(b) (1) Of the sums appropriated under this Act for any fiscal year, not less than ~~5 per centum and not more than 20 per centum~~ may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.

PROPOSED AMENDMENTS

tions (or combinations thereof) for SERVICE OR demonstration programs and projects. . . .

(1) for the FUNDING of training programs for. . .

. . .such services; AT LEAST ONE NON-FEDERAL CENTER TO BE KNOWN AS A REGIONAL RESOURCE CENTER SHALL BE ESTABLISHED AND MAINTAINED IN EACH OF THE TEN DEPARTMENT OF HEALTH, EDUCATION AND WELFARE REGIONS. THE SECRETARY SHALL ESTABLISH MINIMAL STANDARDS OF STAFF EXPERIENCE IN DIRECT SERVICES AND RESEARCH IN THE AREA OF CHILD ABUSE AND NEGLECT, AVAILABILITY OF DIRECT SERVICES MODELS FOR THE EVALUATION AND TREATMENT OF CHILD ABUSE AND NEGLECT, PREPARATION FOR EXPERT CASE CONSULTATION IN THE AREA OF CHILD ABUSE AND NEGLECT, AND OTHER IMPORTANT RESOURCES FOR PROJECTS FUNDED UNDER THIS SECTION.

Not MORE THAN 30 per centum NOR LESS THAN 20 PER CENTUM . . .

(b)(1) Of the sums appropriated under this Act for any fiscal year, not less than 60 percentum. . .

. . .treatment programs. OF THE TOTAL AMOUNT APPROPRIATED UNDER THIS SUBSECTION (b)(1), NO STATE SHALL RECEIVE MORE THAN ITS PROPORTIONAL ALLOWANCE AS DETERMINED BY THE NUMBER OF PERSONS AGE 18 OR UNDER IN THE GRANTEE STATE DIVIDED BY THE TOTAL NUMBER OF PERSONS AGE 18 OR UNDER IN THE UNITED STATES AS DETERMINED BY THE MOST RECENT UNITED STATES CENSUS ESTIMATES.

(2)

(A) ~~have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution~~, under any State or local law, arising ~~out of such reporting;~~

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation ~~shall be initiated promptly to substantiate~~ the accuracy of the report, and, upon a finding of abuse or neglect, ~~immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;~~

(D) demonstrate that there are ~~in effect throughout the State~~, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) ~~provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians;~~

(2) In order for a State to qualify for assistance under this subsection, such State shall --

(A) (From original [b][2][D] Demonstrate that there are OR WILL BE IN EACH COUNTY in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be REASONABLY necessary or appropriate for A GIVEN COUNTY to assure that the State will deal effectively with child abuse and neglect cases in the State;

(B) MEASURE THE ADEQUACY OF SERVICES IN EACH COUNTY, WITH DUE REGARD FOR RELATIVE POPULATION SIZE AND RESOURCES LOCALLY AVAILABLE, BY COMPARING THE POTENTIAL RANGE OF PUBLIC AND PRIVATE SERVICES TO THE ACTUAL NUMBER AND QUALITY OF CHILD PROTECTIVE SERVICES AVAILABLE AND USED FOR CHILDREN, SUCH SERVICES TO INCLUDE, BUT NOT BE LIMITED TO: A HOTLINE AND CENTRAL REGISTRY REPORTING SYSTEM, CRISIS REFERRAL NETWORKS FOR CONSULTATION, PARENTS' GROUPS FOR THERAPY OR PUBLIC AWARENESS, SUCH AS PARENTS ANONYMOUS, CHILD ADVOCACY ORGANIZATIONS, LAY THERAPY, GUARDIANS AD LITEM, GROUP THERAPY, SPOUSE AND FAMILY SHELTERS, THERAPEUTIC NURSERY SCHOOLS, OUTREACH SERVICES AND CRISIS NURSERIES.

(C) ASSURE THAT THE EFFORTS OF ALL ORGANIZATIONS WHICH PROVIDE CHILD PROTECTIVE SERVICES, WHETHER PRIVATE OR PUBLIC, AND IRRESPECTIVE OF FUNDING SOURCE, ARE COORDINATED WITHIN AND BETWEEN EACH COUNTY OF THE STATE.

(D) THE SECRETARY SHALL ISSUE REGULATIONS REVISED ON A PERIODIC BASIS, TO ASSURE THAT STANDARDS SET FOR STATES AND COUNTIES REFLECT THE CURRENT STATE OF KNOWLEDGE OF CHILD ABUSE AND NEGLECT AND CHILD PROTECTIVE SERVICES. SUCH REGULATIONS SHALL INCLUDE PROVISIONS FOR A PLAN TO BE SUBMITTED BY EACH STATE DEMONSTRATING HOW CHILD ABUSE AND NEGLECT PROGRAMS WILL BE BROUGHT INTO CONFORMITY WITH MINIMAL FEDERAL STANDARDS.

(E) provide for the ~~cooperation of law enforcement officials,~~ courts of competent jurisdiction, and ~~appropriate State agencies providing human services;~~

(F) provide that in ~~every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;~~

(G) provide that the ~~aggregate of support for programs or projects~~ related to child abuse and neglect assisted by State funds ~~shall not be~~ reduced below the level ~~provided during fiscal year 1973,~~ and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of ~~State funds which would, in the absence of Federal funds, be available for such programs and projects;~~

(H) provide for dissemination of ~~information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect; and~~

(I) to ~~the extent feasible, ensure that parental organizations combating child abuse and neglect receive preferential treatment.~~

(3) Programs or projects related to child abuse and neglect assisted under part A or B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), and (F) of paragraph (2).

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

~~(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.~~

~~(e)~~ For the purposes of this section, the term "State" includes each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, the Virgin Island, Guam and the Trust Territories of the Pacific.

(d) For the purposes . . .

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purposes of this Act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, and $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal year

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the ~~date of enactment~~ of this Act, appoint an Advisory Board on Child Abuse and Neglect ~~(hereinafter~~ referred to as the "Advisory Board"), which ~~shall be composed of representatives~~ from Federal agencies ~~with responsibility for programs and activities~~ related to child abuse and neglect, including the Office of Child Development, the Office of Education, ~~the National Institute of Education, the National~~ Institute of Mental Health, ~~the National Institute of Child Health and Human~~ Development, the ~~Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating~~ programs and activities ~~related to child abuse and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the~~ development of Federal ~~standards for child abuse and neglect prevention and treatment programs and projects.~~

(b) The Advisory Board shall ~~prepare and submit, within eighteen months~~ after the date of ~~enactment~~ of this Act, ~~to the President and to the Congress a~~ report on the ~~programs assisted under this Act and the programs, projects, and~~ activities related to child abuse and neglect ~~administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.~~

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or ~~$1,000,000~~, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

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* Amendments Section 2(c) and Section 4(e) added by P.L. 93-644, approved January 3, 1975.

LEGISLATIVE HISTORY:
HOUSE REPORT No. 93-685 (Comm. on Education and Labor).
SENATE REPORT No. 93-308 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
July 14, considered and passed Senate.
Dec. 3, considered and passed House, amended.
Dec. 20, Senate agreed to House amendments with amendments.
Dec. 21, House concurred in Senate amendments.

PROPOSED AMENDMENTS

SEC. 6. (a) The Secretary shall, within sixty days after the date of THIS AMENDMENT TO THE "CHILD ABUSE PREVENTION AND TREATMENT ACT," APPOINT AN ADVISORY BOARD ON CHILD ABUSE AND NEGLECT (HEREINAFTER REFERRED TO AS THE "ADVISORY BOARD"), which SHALL be composed of 15 MEMBERS REPRESENTATIVE OF THE NATION AT LARGE, REPRESENTATIVE OF EXPERTISE WITHIN THE SUBSTANTIVE AREA OF CHILD ABUSE AND NEGLECT, AND REPRESENTATIVE OF THE RELEVANT PROFESSIONS INCLUDING BUT NOT LIMITED TO MEDICINE, PSYCHIATRY, LAW, SOCIAL WORK, AND PSYCHOLOGY, THE TERMS OF 5 MEMBERS TO EXPIRE TWO YEARS AFTER APPOINTMENT, THE TERMS OF 5 MEMBERS TO EXPIRE FOUR YEARS AFTER APPOINTMENT, AND THE TERMS OF 5 MEMBERS TO EXPIRE SIX YEARS AFTER APPOINTMENT, WITH SUBSEQUENT APPOINTMENTS TO BE FOR A PERIOD OF 6 YEARS EACH.

(b) NO MORE THAN ONE-THIRD OF THE MEMBERS OF THE ADVISORY BOARD SHALL BE FROM ORGANIZATIONS FEDERALLY-FUNDED.

(c) . . .or $475,000, whichever is the lesser. . .

PREDICTION AND PREVENTION OF CHILD ABUSE AND NEGLECT

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ABSTRACT

Utilizing an interview, a questionnaire, and observations during labor, delivery, and the postpartum period, a sample of one hundred mothers was identified as at high risk for abnormal parenting practices. These mothers were randomly divided into a "High-Risk Intervene" group (N=50) and a "High-Risk Nonintervene" group (N=50). The "Intervene" group received comprehensive pediatric follow-up by a single physician, a lay health visitor, and/or a public health nurse in the home. The "Nonintervene" group received routine care, although the results of these screening procedures were shared with the physicians and nurses responsible for their ongoing care. Another group of 50 mothers, who delivered during the same time period and who were assessed as low risk in terms of abnormal parenting practices, served as controls. When the children were approximately two years old (mean age 26.8 months), 25 families in each of the three groups were chosen at random for detailed evaluation.

Results: 1) A high-risk group was successfully identified by the use of perinatal screening procedures; these children had encountered significantly different parenting practices than had the low-risk "control" group. 2) Five children in the "High-Risk Nonintervene" group required hospitalization for serious injuries thought to be secondary to abnormal parenting practices, as contrasted to no such hospitalizations in the "High-Risk Intervene" and "Low-Risk" control groups. 3) Labor-delivery observations, and nursery interviews and observations, provided the most accurate predictive information; prenatal interviews and questionnaires did not add significantly.

Perinatal assessment and simple intervention with families at high risk for abnormal parenting practices significantly improves the infants' chances for escaping physical injury.

INTRODUCTION

Child abuse is a major problem affecting many thousands of children from all social strata. Increasing knowledge of the general factors that operate in causing children to be abused has resulted in earlier and more accurate diagnosis. Effective therapy is now being instituted at the first indication of injuries in an attempt to break the cycle of parent-induced child abuse and neglect. Although the overall dynamics operating to produce child abuse and neglect are becoming better understood, the specific factors that allow us to predict abnormal child-rearing patterns in certain families have not been generally established. The ability to make accurate predictions of abnormal parenting practices will greatly facilitate the initiation of effective intervention before significant damage has been allowed to occur.

This study examines the feasibility of predicting the potential for some abnormal child-rearing practices, of which child abuse and neglect is one extreme. It concentrates on the perinatal and early neonatal periods, since these offer an excellent opportunity to make assessments of a newborn infant's behavior, to observe the mother's and father's responses to their child, and to study the interaction between them. The perinatal period also provides easy accessibility to individuals as they become a family, permits observations of the mother and child during a critically sensitive time (1), and allows pediatric intervention to begin early whenever there is indication that potentially harmful child-rearing patterns may occur. Intervention at this time can be aimed at increasing strengths within the family so that a child may have the opportunity to reach his physical, emotional and intellectual potential.

METHODS

From November 1971 to March 1973, a population sample was drawn from 350 mothers who were having either their first or second child at Colorado General Hospital. Infants with neonatal conditions severe enough to require transfer to the neonatal intensive care unit were excluded from the study.

Some or all of the following screening procedures were carried out to determine which of them were most likely to be predictive of "abnormal parenting practices."

1. Collection of prenatal information: Data were gathered regarding the parents' upbringing, feelings about this pregnancy, expectations for the unborn child, attitudes towards discipline, availability of support systems, and the present living situations. (Table 1a)

2. Administration of a questionnaire: (2) A 74-item questionnaire was administered to the mother during the prenatal or early postnatal period. The questions covered information

similar to that obtained in the prenatal interview (see No. 1 above).

3. Assessment of labor and delivery room information: These data were collected by one or more of the following methods:

a. Mother-infant interaction forms were completed by the labor and delivery room nurses. The nurses recorded the parents' verbal and nonverbal interactions with their child during their first encounter with him/her (Table 1b). The nurse also added any additional pertinent observations about the parents' behavior.

b. In a number of instances, with the parents' permission, videotapes were made of mothers' and infants' interaction so as to be able to carry out a more thorough assessment of the quality of this interaction and to check the accuracy of observations made by labor and delivery room nurses and physicians.

c. The delivery room staff was encouraged to provide anecdotal information regarding their observations of the parents and children. This information was also utilized to assess parenting potential (Table 1b).

4. Observations and/or interview during the postpartum period: During the postpartum period, the parents were again interviewed to obtain or expand on information gained during the prenatal interview (see No. 1 above and Table 1c). Information obtained from direct observation of the mother-infant interaction during the postpartum stay in the hospital was also recorded.

From the data gathered in two or more of these areas, parents were assessed as to their parenting potential. One hundred mothers identified as having psychologic, interactional, and life-style dynamics (3-5) which might result in "abnormal parenting practices" were randomly assigned to a "High-Risk Intervene" group (N=50) or a "High-Risk Nonintervene" group (N=50). Fifty mothers who also delivered their first or second child at the hospital in the same time period and who were assessed as low-risk in terms of abnormal parenting potential were selected as controls.

"Intervention" in this study meant the provision of pediatric care by one pediatrician at the Medical Center where the child was born. This pediatrician examined the infant during his stay in the newborn nursery, talked with the parents on the postpartum ward, and scheduled the first pediatric clinic visit to take place before the infant was two weeks old. Thereafter, the pediatrician saw the child at scheduled bimonthly visits. Additional pediatric visits took place whenever the doctor or the mother felt that the child should be seen. In addition to seeing the child during visits to the clinic, the pediatrician also contacted the family by telephone two or three days after discharge from the hospital, as well as during the subsequent weeks when a clinic visit was not scheduled. Additional telephone calls were initiated by the pediatrician to ascertain the status of any problems that may have become apparent in previous clinic visits and/or telephone conversations. The physician also contacted the family to provide support to them whenever a medical or other crisis was known to be present. It was not pointed out to the study families that this service was exceptional; it was simply provided as part of the child's well-baby care.

In addition to the contact between the pediatrician and the family, "intervention" also included weekly visits to the home by public health nurses. The public health nurses had been notified of the pertinent findings obtained by the interview, assessment of the delivery room interaction, and the questionnaires. Whenever necessary, referrals were made to other medical facilities or mental health clinics. Lay health visitors (6) (lay persons who visited in the homes to assess the general health status of the child, to offer emotional support to the entire family, and to provide liaison with the professional health system) were utilized whenever indicated.

"Nonintervention" meant that the investigators did nothing directly for the family after discharge. However, all of the available information was routinely shared with attending hospital staff, community agencies such as visiting nurse service, and the family physician or clinic.

When a child was between the ages of 17 and 35 months (mean age 26.8 months) a home visit was made to 25 randomly-selected families in each of the three categories: "High-Risk Intervene" (HRI), "High-Risk Nonintervene" (HRN), and "Low-Risk" (LR). During this home visit, the mother was interviewed and medical and social information involving the entire family was collected. Also, observations of mother-child interaction were made and the Denver Developmental Screening Test (DDST) was administered to the child.

The incidence of various findings was determined for each child during the first 17 months of life (at the time of detailed evaluation, the youngest child was 17 months old). In order to determine whether a group at risk for deficient parenting had actually been predicted, children were assessed for the presence of incidents of "abnormal parenting practices," which included all verified reports of abuse and neglect to the Central Child Abuse Registry, injury secondary to lack of adequate care and supervision, injuries suspicious for inflicted trauma, failure to thrive which was thought to be secondary to deprivation (7), relinquishments, foster care placements, and parental kidnappings. Children were also assessed as to the number of incidents of trauma thought to be true accidents, reasons why children were no longer in their biologic homes, their immunization status, and their performance on the Denver Developmental Screening Test.

Central Child Abuse Registry reports and indications of "abnormal parenting practices" involving medical concern were categorized for all three study groups as a comparison of the effect of intervention.

Data were also compiled to help indicate which of the four screening procedures (prenatal interview, questionnaires, labor and delivery room observations, or postpartum interviews and observations) resulted in the greatest percentage of correct predictions of "parenting potential."

The three groups were compared by ordinary chi square tests appropriate for 3 by 2 contingency tables. These "total" chi squares were partitioned into single degrees of freedom chi squares appropriate for comparing the two high-risk groups with the low-risk group (HR vs. LR) and the "High-Risk Intervene" group with the "High-Risk Nonintervene" group (HRI vs. HRN), as discussed by Kastenbaum (8). (See Table 4.)

RESULTS

1. The Ability To Predict

a. Indications of abnormal parenting: By the time of detailed evaluation there were 22 indications of "abnormal parenting practices" in the high-risk groups (25 HRI and 25 HRN) and 2 indications in the control group of 25. The high-risk groups differed significantly from the low-risk group ($p <.01$). In the total population sample (150 children), eight high-risk children and no low-risk children were reported to the Central Child Abuse Registry ($p < .04$).

There were 3 cases of failure to thrive (weight below the third percentile, height and head circumference above the third percentile) thought to be secondary to deprivation (7) in the HRI group. Although children in the HRN group were not followed as closely, information was obtained by chart review and contact with the child's physician that two of these children exhibited failure to thrive thought to be secondary to deprivation. There were no such cases in the low-risk group.

b. Accidents: There were 31 children in the high-risk groups and 11 children in the low-risk group who had sustained at least one accident which required medical attention during the time period of the study. During the first 17 months of life, 22 children in the high-risk groups and 4 children in the low-risk group had at least one accident requiring medical attention ($p < .02$).

c. Immunization status: At one year of age, 47 out of the 50 high-risk children (25 HRI and 22 HRN) were up to date with their immunizations. In the low-risk group, 24 of 25 had similar immunization status. The difference in the groups is not statistically significant.

d. Denver Developmental Screening Test: DDST assessment of high-risk children revealed that there were 3 whose results were recorded as questionable, 3 children who were untestable, and 44 who were normal (9). In the low-risk group, all 25 were normal. There is no statistically significant difference between these groups. If the results of the DDST are examined by counting the number of clear failures (test items to the left of the child's chronological age), 10 high-risk children versus no low-risk children had clear failures ($p < .02$).

e. Reasons for no evaluation: There was a significantly increased incidence ($p < .04$) of infants assessed as being at risk for "abnormal parenting practices" not being in their biologic home at the time of the follow-up evaluation. All low-risk children were in their biologic home; but 8 high-risk children were either in foster care, permanently living with relatives, or had been legally relinquished.

2. Results of Intervention on the Incidence and Outcome of Abnormal Parenting Practices

a. Incidence: Between the HRI group and the HRN group there were no significant statistical differences on the basis of Central Child Abuse Registry reports, indications of "abnormal parenting practices," accidents, immunizations, or Denver Developmental Screening Test scores.

b. Outcome: Another way to measure the effect of intervention within the high-risk groups is to describe the quality of differences in the types of "abnormal parenting practices" that occurred. No child in the low-risk group and no child in the HRI group suffered an injury thought to be secondary to "abnormal parenting practices" that was serious enough to require hospitalization for treatment. However, five children in the HRN group required inpatient treatment for serious injuries ($p < .01$). These injuries included a fractured femur, a fractured skull, barbiturate ingestion, a subdural hematoma, and third-degree burns. Although these five injuries were treated in local hospitals, only two of them had been reported to the Central Child Abuse Registry.

3. Screening Procedures

Information from observations of labor and delivery room interactions was analyzed individually and resulted in 76.5% correct predictions of parenting potential. The questionnaire alone resulted in 57.5% correct predictions. The prenatal interview alone resulted in 54.4% correct predictions, and the postpartum interview/observations resulted in 54% correct predictions. If all four parameters are included together, they resulted in 79% correct predictions.

During the initial interviews and observations, four factors were considered as possible indicators of high risk: the mother's race, the family's socioeconomic status (as determined by the hospital's financial ratings), the mother's marital status, and the mother's age. In the study population, the mother's race did not prove to be a significant variable. There was a trend toward "financial difficulty" in mothers in the high-risk groups. The mother's marital status and age differed significantly between the high-risk groups and the low-risk group; single and young mothers were considered to be at higher risk for abnormal parenting practices.

DISCUSSION

Child abuse is now being reported approximately 300,000 times each year in our country. The figure rises to 1 million if neglect is included. About 60,000 children have significant injuries; about 2,000 die and 6,000 have permanent brain damage (6). Multidisciplinary research (sociologic, pediatric, nursing, psychiatric, and legal) has made possible earlier diagnosis and more successful treatment programs; however, as in many other aspects of medicine, prevention is the ultimate goal.

Medical and nursing staff who work in the prenatal, labor and delivery area and the neonatal nursery are ideally situated to make sensitive observations of a family's interactional behavior. The assessment of attitudes and feelings has been a part of pediatrics for many years. It is now time to formally utilize these assessments in the implementation of supportive intervention for families in need. Systematic use of a prenatal interview, questionnaire, labor and delivery observations, and postpartum interviews/observations can identify a population at risk for "abnormal parenting practices." These data show that accurate prediction of families in need of extra services is possible, as evidenced by the statistical differences between the high-risk groups and the low-risk group in the areas of "abnormal parenting practices," Central Child Abuse Registry reports, the number of accidents (by 17 months of age), children no longer in their biologic homes, and children exhibiting clear failures on the DDST.

It is a belabored point that battering parents tend to lack motivation toward initiating helping services. However, when the health care providers (pediatricians, public health nurses, and lay health visitors) initiate an outreach approach with high-risk families, a comprehensive medical program can be successful.

Recently there has been an increased awareness of the abnormal behavior characteristics and the developmental lags seen in abused children (10, 11). This has been observed in the children after documentation of abuse, but with the assumption that the children have been living in an "abusive environment" prior to the physical abuse. In this study, 20% of children thought prospectively to be at risk for abnormal parenting had at least one clear failure on the DDST. These are children thought to be living in an environment deficient in parenting.

Now that it is largely possible to identify a population at risk for "abnormal parenting practices," the next step is to determine the success and practicality of initiating early intervention with these families. Although there was no statistically significant difference in the incidence of "abnormal parenting practices" between the HRI and the HRN groups, there was a qualitative difference in the injuries in the study groups. In the HRI and the low-risk groups, no child required hospitalization for treatment of a serious injury thought to be secondary to "abnormal parenting practices. However, in the HRN group five children required treatment for trauma or poisoning. One of the five serious injuries (the burns) was preceded by relatively minor inflicted trauma, including cigarette burns, scratch marks and strap marks. These all received medical attention but were never reported, nor was an attempt made to involve other helping agencies in an effort to prevent further injuries. There is a possibility that the third-degree burns and the resulting contractures could have been prevented if intervention had been initiated promptly. In another case, a subdural hematoma and its resulting intellectual deficit and neurologic handicap might have been prevented if intervention had been instituted during a "social admission" to a hospital just prior to the injury. If appropriate interventions to alleviate social pressure had been undertaken at this point, there is a possibility that the injury would not have occurred. In the low-risk group, injuries (a minor burn and a metacarpal fracture) thought to have occurred because of negligence both involved children over two years of age. These children were well into the accident-prone toddler years, whereas injuries in the high-risk groups occurred at younger ages.

There was also an increased incidence of failure to thrive in the high-risk groups. Early identification and effective intervention in one case of failure to thrive in the HRI group was therapeutic for that child. This baby was promptly hospitalized at five weeks of age when failure to thrive was discovered. The weight gain was re-established in the hospital and failure to thrive completely resolved by four months of age. On the two-year follow-up, the child had normal growth parameters.

Therefore, in the HRI group, it appears that modest intervention precluded any injuries severe enough to require hospitalization for treatment and any injury that resulted in prolonged disability. The less serious injuries and the failure-to-thrive baby in the HRI group were promptly reported and effective community intervention established, which may have prevented subsequent, more serious problems.

The concept of early preventive pediatric and community intervention will, it is hoped, lead to progress in prevention of the harmful effects of child abuse and neglect. Families identified as being in need of extra services must have access to intensive, continuous intervention which is both positive and supportive. It makes little sense to provide excellent prenatal, obstetrical and neonatal pediatric care in our hospitals, only to abandon the most needy young families at the hospital door and leave to chance, or to parent motivation, the needed access to helping professionals.

SUMMARY

In this study, information gained from observers in the delivery room was most accurate in predicting potential for abnormal parenting practices. The questionnaire did not add significantly to the accuracy of prediction. If delivery room observation is not feasible and only one opportunity for evaluation exists, the early postpartum period affords the best opportunity for collection and analysis of prenatal, labor and delivery, and postpartum observations. Such observations are non-invasive and should be part of obstetrical and postpartum routine.

Immediate, effective intervention by physicians, public health nurses, and/or lay health visitors can significantly decrease many "abnormal parenting practices." In this study, such intervention prevented serious injury in a high-risk population.

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TABLE 1 Warning Signs

These are indications of possible problems. A high-risk situation is created by varying combinations of these signs, the family's degree of emphasis upon them, and the family's willingness to change. The interviewer must take into consideration the mother's age, culture, and education, as well as observations of her affect and the significance of her feelings. Many of these signs can be observed throughout the perinatal period; they are listed in this order because they are found most commonly at these times.

1a - Observations during the prenatal period

The mother seems overly concerned with the baby's sex or performance.

The mother exhibits denial of the pregnancy (not willing to gain weight, no plans for the baby, refusal to talk about the situation).

This child could be "one too many."

The mother is extremely depressed over the pregnancy.

The mother is very frightened and alone, especially in anticipation of delivery. Careful explanations do not seem to dissipate the fears.

There is lack of support from husband and/or family.

The mother and/or father formerly wanted an abortion or seriously considered relinquishment and have changed their minds.

The parents come from an abusive/neglectful background.

The parents' living situation is overcrowded, isolated, unstable, or is intolerable to them.

They do not have a telephone.

There are no supportive relatives and/or friends.

1b - Observations during delivery

Written form with baby's chart of parent's reaction at birth.

How does the mother LOOK?

What does the mother SAY?

What does the mother DO?

When the father attends delivery, record his reactions as well.

Passive reaction, either verbal or non-verbal: mother doesn't touch, hold, or examine baby, nor talk in affectionate terms or tones about the baby.

Hostile reaction, either verbal or non-verbal: mother makes inappropriate verbalizations, glances, or disparaging remarks about the physical characteristics of the child.

Disappointment over sex of the baby.

No eye-contact.

Non-supportive interaction between the parents.

If interaction seems dubious, talk to the nurse and doctor involved with delivery for further information.

1c - Observations during the postpartum period

The mother doesn't have fun with the baby.

The mother avoids eye contact with the baby and avoids the direct *en face* position.

The verbalizations to the infant are negative, demanding, harsh, etc.

Most of the mother's verbalizations to others about the child are negative.

The parents remain disappointed over the sex of the child.

Negative identification of the child: significance of name, who he/she looks like and/or acts like.

The parents have expectations developmentally far beyond the child's capabilities.

The mother is very bothered by crying; it makes her feel hopeless, helpless, or like crying herself.

Feedings: the mother sees the baby as too demanding; she is repulsed by his messiness, or ignores his demands.

Changing diapers is seen as a very negative, repulsive task.

The mother does not comfort the baby when he cries.

The husband's and/or family's reactions to the baby have been negative or non-supportive.

The mother is receiving little or no meaningful support from anyone.

There are sibling rivalry problems or a complete lack of understanding of this possibility.

The husband is very jealous of the baby's drain on mother's time, energy and affection.

The mother lacks control over the situation. She is not involved, nor does she respond to the baby's needs, but relinquishes control to the doctors or nurses.

When attention is focused on the child in her presence, the mother does not see this as something positive for herself.

The mother makes complaints about the baby that cannot be verified.

TABLE 2 Positive Family Circumstances

1. Parents see likable attributes in baby, see baby as separate individual.
2. Baby is healthy and not too disruptive to parents' lifestyle.
3. Either parent can rescue the child or relieve the other in a crisis.
4. Marriage is stable.
5. Parents have a good friend or relative to turn to, a sound "need-meeting" system.
6. Parents exhibit coping abilities; i.e., capacity to plan and understand need for adjustments because of new baby.
7. Mother's intelligence and health are good.
8. Parents had helpful role models when growing up.
9. Parents can have fun together and enjoy personal interests or hobbies.
10. This baby was planned or wanted.
11. Future birth control is planned.
12. Father has stable job.
13. Parents have their own home and stable living conditions.
14. Father is supportive to mother and involved in care of baby.

TABLE 3 Special Well-Child Care for High-Risk Families

1. Promote maternal attachment to the newborn.
2. Contact the mother by telephone on the second day after discharge.
3. Provide more frequent office visits.
4. Give more attention to the mother.
5. Emphasize nutrition.
6. Counsel discipline only around accident prevention.
7. Emphasize accident prevention.
8. Use compliments rather than criticism.
9. Accept phone calls at home.
10. Provide regular home visits by Public Health Nurse or Lay Health Visitor

TABLE 4 Summary of Statistical Analysis

Item	HRI	HRN	LR	Partitioned χ^2 results		
				HR-LR	HRI-HRN	Total
Total study population(150): Central Registry reports	6	2	0	p <.04	p <.08	p <.03
Detailed evaluation of population (25 in each category)						
Central Registry reports						
at time of home evaluation (mean 26.8 months)	2	1	0	p <.22	p <.48	p <.36
by 17 months of age	1	1	0	p <.60	p <.99	p <.30
Indications of abnormal parenting practices						
by time of home evaluation	11	11	2	p <.01	p <.99	p <.01
by 17 months of age	10	10	0	p <.01	p <.99	p <.01
Failure to thrive	3	2	0	p <.20	p <.60	p <.30
DDST not normal						
by test manual (see Ref. 9)	3	3	0	p <.08	p <.99	p <.20
by failed items	7	3	0	p <.02	p <.10	p <.02
Accidents						
by time of home evaluation	16	15	11	p <.14	p <.78	p <.33
by 17 months of age	12	10	4	p <.02	p <.56	p <.05
Not in biologic home	5	3	0	p <.04	p <.36	p <.07
Appropriate immunization status at one year	25	22	24	p <.72	p <.16	p <.16
Inpatient treatment for injury	0	5	0	p <.11	p <.01	p <.01

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THE NEONATAL INTENSIVE CARE NURSERY AS A TARGET SITE FOR PREDICTING CHILD ABUSE AND NEGLECT

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Introduction

In recent years, technological advances and increased availability of neonatal intensive care units have been cited as major factors in improving the survival and health status of high risk prematures and other newborns with special problems. At the same time, retrospective studies in the child abuse literature have hinted that these special newborns may run a much increased risk for subsequent abuse and neglect. This aspect of their vulnerability appears to persist despite improvements in neonatal intensive care. The hospital care required for sick newborns frequently means that infant and family are separated for a long period of time and often at significant geographic distance. Indeed, the very advances which have improved medical care may actually be adding to the psychosocial vulnerability of high risk newborns by erecting blockades to early parent - infant attachment. The most extreme result is seen in later child abuse or neglect.

While all infants in a neonatal intensive care nursery would appear to be at some increased risk for subsequent maltreatment, an important need would seem to be the development of methods for predicting those infants at highest risk so that limited intervention resources could be accurately focused. It was our hypothesis that families whose coping capacities were already limited would be least able to adapt to the burdens critically ill infants impose, leading to the disproportionate number of these children who are later reported for abuse or neglect. The development, implementation and assessment of a predictive tool to identify such families in the nursery is examined in this presentation.

Materials and Methods

Our work with parents in a regional intensive care unit and followup clinic provided the setting for examining factors which might be predictive of subsequent child abuse and neglect. The babies in this study were all hospitalized in the Newborn Intensive Care Unit of North Carolina Memorial Hospital, a state referral hospital and teaching institution. Sick newborns referred from hospitals throughout the state equal admissions of infants born at Memorial. The admission rate during the period of this study was approximately one infant per day, with referrals from 47 of the States 100 counties. Significant geographic separation of family and infant is frequent, although the nursery supports parent-infant interaction through a policy of unlimited in-nursery visiting of parents and grandparents with encouragement to touch and handle infants.

Families of all babies admitted to the nursery between May, 1975 through June, 1976 (422) comprised the base of the study population. Excluded were 130 families due to the very brief stay of their infants in the nursery. The unassessed brief stay group consisted predominantly of well infants who were rapidly transferred back to a regular nursery, or very sick ones who expired soon after arrival. Considered eligible, with stays on the unit of seven days or more, but not included were 21 families whose contacts with the project staff were inadequate for full assessment. The remaining 271 families with their 282 newborns are the subject of this report.

An initial, semi-structured interview by the nursery social worker or child psychiatrist, held as soon as possible after admission, provided the data for predicting risk for each baby. A list of maltreatment risk indicators was developed from the current literature on the etiology of child abuse and neglect with special attention to maternal personality characteristics described by Polansky and co-workers in their work with families in the rural southeast. Items assessing the family's adaptation to the index pregnancy and birth are also prominent on the list. This 24-item risk inventory was scored immediately following the family interview. Items were equally weighted and scored 0 (not present), 1 (present to some degree), or 2 (strongly present). Total risk scores were derived by summing scores of the individual items. Since all items were negatively stated, high scores indicated predicted high risk for maltreatment. Forty families were assessed and rated independently by both interviewers. A comparison of inter-rater reliability in assessing these families showed a high degree of agreement on total risk scores. In no case did interviewers vary by greater than three points in assessing any of these families, and in two-thirds of cases total risk scores agreed or varied by only one point. In those cases where there was disagreement between interviewers, mean risk scores were used, and for purposes of item analysis, any item endorsed by either scorer was included.

A pattern of distribution of scores emerged during the first two months of the study which allowed the assignment of families to high and low risk groups on the basis of total risk scores. Many intervention activities were directed at both groups of families. All parents were encouraged to take advantage of the nursery's unlimited visiting policy, were provided supportive crisis counseling, assistance with financial arrangements, and access to hospital-based overnight accomodations. Public health nurse referrals and post-discharge followup in a special multidisciplinary clinic were also provided to families in both groups.

For high risk infants, an effort was made to involve local agencies in planning supportive services during and after the baby's hospitalization. Liaison work with county agencies was accomplished by telephone, letter, and by planning sessions involving project staff and community service providers. In addition, all of the high risk infants were brought to the attention of their county department of social services, protective services division.

Sociodemographic and medical characteristics of mothers and babies were studied by chart review. Followup has lasted from 6 to 18 months and outcome data is based on continued contact with families in clinics, liaison with local care providers, and review of clinical records. In addition, the state death records and central registry of abused and neglected children were searched for all children included in the study.

Results

The distribution of total risk scores for the 282 infants studied is shown in Figure 1. A majority of the infants (82%) followed a distribution curve with scores ranging from 0 to 9 (low risk group). Total scores identified a second group (18%) with scores ranging from 10 to 24 (high risk group).

Clinical outcome at 6 to 18 months has confirmed the risk status of this latter group with 10 reported cases of abuse and neglect occurring among those infants predicted to be at high risk.

In addition to predicting infants subsequently reported for maltreatment, the indicators also selected all babies who were relinquished or placed directly from the nursery (Table I). There were no reports of abuse or neglect in the

[illegible]

low risk group nor were there any relinquishments in the nursery or subsequent custody changes. Due to the events befalling the high risk babies, only 59% remained in their parental home at 6 to 13 months followup, compared with 88% of those in the low risk group.

Further analysis of differences between risk groups were examined by chi square and T-tests, and a significance level of p less than .05 was set for differences between high and low risk groups. Because of the short follow-up period trends significant at p less than .10 were considered in the more fluid reported vs. not reported groups.

Item analysis of the risk indicators (Table II) demonstrated that high risk families differed significantly from the rest of the population on 17 of the 24 predictors studied. Adolescence, inexperience in child care, and previous reproductive problems were equally common and not useful predictors. Five personality - psychiatric factors (verbal inaccessibility, retardation, psychosis, alcohol and drug abuse, and criminal histories) were all more common in the high risk group, yet appeared infrequently in the population as a whole and did not reach statistical significance.

When high risk families reported for child abuse and neglect are compared with high risk families who have their babies at home yet have not been reported during the period of the study, adolescence becomes a negative predictor, with the majority of high risk adolescents falling into the not reported group. Four predictors show a significant progression in distinguishing between low and high risk families and reported vs. not reported high risk families. These are a poor social support system, inadequate child spacing, the apathetic - futile personality style, and a family history of abuse or neglect, which was found in all of the high risk families who were subsequently reported.

An analysis of sociodemographic maternal facotrs (Table III) revealed that mothers predicted to be high risk were also more likely to be younger, black, unmarried, and living in situations other than with the father of the baby. Their mean level of education was two years less than low risk mothers. Looking only at those high risk mothers subsequently reported for child maltreatment, we again see the reversal of age as a predictor with 80% of reported mothers being older than 20 years compared with only 32% of those not reported. In other ways, the reported group also resembled more closely the low risk mothers in terms of demographic data. That is, they were more likely to be white, to be married, to be living with the father of the baby, and to have completed high school, although these differences fail to reach statistical significance. Interestingly, although significantly more high risk mothers were predicted among those living within 50 miles of the nursery, those eventually reported for abuse and neglect lived outside this perimeter by a ratio of about 2 to 1.

The high and low risk groups were similar in terms of parity, (Table IV) but high risk mothers reported for abuse and neglect were significantly less likely to be primigravidas; more likely to have had three or more pregnancies. Their increased pregnancies resulted in equal increases of full term babies, previous prematures, stillbirths and abortions, and living children, although these findings did not reach statistical significance. Complications of pregnancy, labor and delivery were similar in all four groups. High risk mothers were also much less likely to obtain a minimum of prenatal care. Only one-half (52%) reported as many as three prenatal visits compared with 87% of low risk mothers. One out of four high risk mothers received no prenatal care including two of the mothers whose babies were subsequently reported for abuse.

Differences were also seen between the high and low risk babies in terms of physical characteristics and medical diagnoses (Table V). Although the percent of prematures represented in each of the four groups was similar, there was a significant difference in birthweights with low risk babies having the highest mean birthweight in the study and high risk babies reported for abuse and neglect having the lowest mean birthweight. Similarly, the percent of infants with birthweights of less than 1500 grams increased progressively from the low risk category (18.3%) to the high risk category (34.1%) to high risk infants reported for maltreatment (70%). All high risk babies reported for maltreatment had birthweights of less than 2500 grams. Babies subsequently reported for abuse were also significantly less mature at birth than infants in the other three groups. Probably related to these factors, the high risk reported babies were twice as likely to have suffered from Idiopathic Respiratory Distress Syndrome (50%). Congenital defects were significantly more frequent in the high risk babies and occurred in one-half of the high risk babies subsequently reported for maltreatment.

High risk reported babies had very long hospitalizations, staying an average of 52 days—more than twice as long as low risk babies or high risk babies not reported for abuse and neglect. Three measures of degree of sickness—the number of days until babies received total nipple feeding, days in oxygen, and days requiring an isolette—all showed a similar pattern with high risk babies reported for abuse and neglect having significantly more days of serious illness.

Discussion

The study confirms a high rate of abuse and neglect among premature and ill newborns receiving care in a neonatal intensive care unit. Ten cases of abuse and neglect during this limited period of followup out of a total population of 255 infants discharged to their parents, represents a rate four times the generally accepted one case per 100 children of maltreatment reported in the general population. One out of four predicted infants discharged to their homes were subsequently reported for abuse or neglect during the study.

Seventeen indicators were useful in delineating a high-risk pool which yeilded all subsequent cases of maltreatment. The usual sociodemographic factors—age, race, education, marital status, etc., were considerably less useful in predicting which infants were ultimately abused. In particular, high-risk adolescent mothers did much better in terms of subsequent reports of abuse and neglect. The study does not explain this finding, but one might speculate that many of the risk indicators hold less pathological significance when present in a teenager compared with a more mature person. For example, unrealistic expectations concerning an infant would be more expected and probably more open to change in a teenager.

The study does not evaluate the extent of intervention activities which may have had an important effect in determining which of the high-risk babies were subsequently reported for abuse and neglect. Again, perhaps adolescents with their first baby are much more responsive to the kinds of intervention public health nurses can provide compared with older, more experienced, high-risk mothers who are more fixed in their child-rearing practices.

It would appear that some combination of evaluation of family characteristics plus data on the baby's hospital course would provide the best predictors of infants at highest risk for abuse and neglect. The study has shown that high-risk babies eventually reported for maltreatment were sicker infants in many ways during their neonatal course. Their hospital stay was extremely prolonged, and with the majority of mothers living greater than fifty miles from the nursery, serious impairment of early parent-infant bonding may well have occurred in this group.

The study tended to confirm the suitability of the neonatal intensive care unit as a target site for predicting child abuse and neglect. The low rate of prenatal care in high-risk families may make the intensive care nursery the only site where some of these families may be identified prior to the first abusive episode. The finding that severity of neonatal illness and length of separation from the family predict likelihood of later abuse in high risk families also makes the neonatal intensive care unit a promising site for intervention activities designed to lessen the impact of these factors.

Fig. 1. Distribution of Risk Scores for 282 Infants

Newborn ICU Child Abuse and Neglect Prediction Project, MCMH, 1975-76

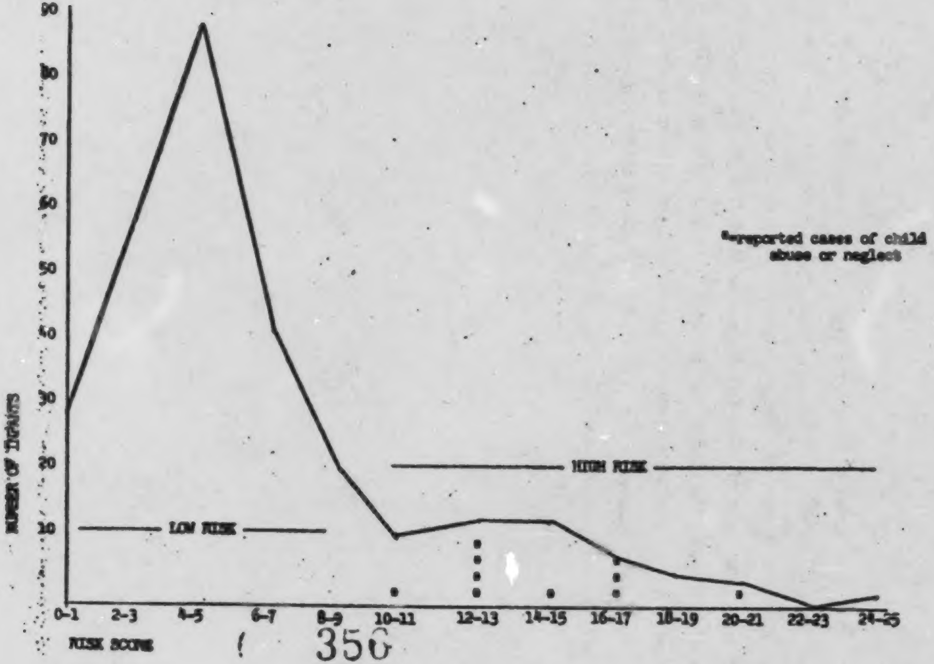

TABLE I. Outcome of 282 Infants by Risk Category*

Newborn ICU Child Abuse and Neglect Prediction Project, NCMH, 1975-76

	HIGH RISK			LOW RISK		
	N	% In Nursery	% At Home	N	% In Nursery	% At Home
Total	52	100		230	100	
Died in nursery	4	7.7		16	6.9	
Relinquished or placed from nursery	7	13.5		0	0	
Discharged to home	41	78.8	100	214	93.1	100
Reported for abuse or neglect	10		24.4	0		0
Custody change after discharge	7		17.1	0		0
Died after discharge	3		7.3	11		5.1
Remaining at home	31	59.6	75.6	203	88.3	94.9

*Mean followup period = 1 year. Range 6-18 months.

11. The Maltreatment Risk Indicators: Comparison of Risk Groups by Percent of Families Positive For Each Item

Newborn ICU Child Abuse and Neglect Prediction Project, NCMH, 1975-76

	LOW RISK N = 230		HIGH RISK N = 52	REPORTED N = 10		NOT REPORTED N = 31
Stresses, Coping Skills, Resources						
Adolescent-inexperienced	59.0		60.4	30	—— *——	74.2
Marital maladjustment	7.9	—— *——	39.4	40		29.0
Financial problems	31.9	—— *——	73.6	70		83.9
Recent major life stress	46.7	—— *——	64.2	80		67.7
Poor use of medical care	4.8	—— *——	37.7	30		38.7
Poor support system	4.4	—— *——	49.1	80	—— *——	41.9
Inadequate child care	3.9	—— *——	62.3	80		61.3
Pregnancy, Birth Adaptation						
Inadequate child spacing	10.5	—— *——	32.1	60	—— *——	22.6
Previous reproductive problems	25.6		24.5	30		25.8
Abortion seriously considered	4.4	—— *——	34.0	50		25.8
Failure to accept pregnancy	5.2	—— *——	41.5	40		32.3
Few preparations for baby	6.1	—— *——	47.2	40		48.4
Lacks parenting confidence	6.6	—— *——	24.5	20		22.6
Unrealistic expectations	5.2	—— *——	28.3	20		41.9
Disappointed in baby's sex	3.0	—— *——	20.8	40		19.4
Personality-Psychiatric						
Impulsive	5.7	—— *——	43.4	30		38.7
Apathetic-futile	4.4	—— *——	20.8	50	—— *——	12.9
Childish-dependent	7.0	—— *——	47.2	50		51.6
Verbally inaccessible	4.8		15.1	20		16.1
Retarded, illiterate	1.3		11.3	20		12.9
Psychosis, depression	1.3		11.3	0		16.1
Alcohol, drug abuse	0.4		7.5	10		9.7
Police, prison record	0		5.7	10		9.7
Family history abuse/neglect	10.9	—— *——	64.2	100	—— *——	61.3

*Significant difference between groups

TABLE III. Comparison of Risk Groups by Maternal Factors

Newborn ICU Child Abuse and Neglect Prediction Project, MCMH, 1975-76

	LOW RISK AT HOME N = 214		HIGH RISK AT HOME N = 41	REPORTED N = 10		NOT REPORTED N = 31
Sociodemographic						
Age: Mean (years)	23.4		20.1	22.5		19.3
% > 20 years	70.7	—— * ——	43.9	80	—— * ——	32.3
Race: % white	58.4	—— * ——	41.5	60		31.5
Marital Status: % married	77.9	—— * ——	48.8	60		45.2
Household: % with father of baby	77.4	—— * ——	39.0	60		32.3
% with mother's family	19.3		34.1	10		41.9
% with other or alone	3.3	—— * ——	26.8	30		25.8
Education: mean (years)	11.9		9.9	10.3		9.8
% completed high school	61.4	—— * ——	22.5	40		16.7
Hospital of delivery: % inborn	48.1		56.1	30		64.5
Home-nursery distance: % within 50 mi.	40.6	—— * ——	65.8	40		74.2

*Significant difference between groups

TABLE IV. Comparison of Risk Groups by Maternal Factors

Newborn ICU Child Abuse and Neglect Prediction Project, NCMH, 1975-76

	LOW RISK AT HOME N = 214	HIGH RISK AT HOME N = 41	REPORTED N = 10	NOT REPORTED N = 31
Medical-Obstetric				
Parity: % primigravida	39.7	39.0	10 ——— * ———	48.4
% gravida 3+	28.0	31.7	60 ——— * ———	22.6
% living children 3+	22.9	26.8	50	19.4
Pregnancy: % complicated	36.4	34.1	30	35.5
Labor and delivery: % complicated	57.9	51.2	50	51.6

*Significant difference between groups

TABLE V. Comparison of Risk Groups by Infant Factors

Newborn ICU Child Abuse and Neglect Prediction Project, NCMH, 1975-76

		LOW RISK AT HOME N = 214		HIGH RISK AT HOME N = 41	REPORTED N = 10		NOT REPORTED N = 31
Physical Characteristics							
Birthweight: mean grams		2240.2	*	1959.8	1446.0	*	2125.6
	% < 1500 gm.	18.3	*	34.1	70	*	22.6
Gestational Age: mean weeks		35.4		34.3	31.7	*	35.3
	% small for age	13.1		14.6	30		9.7
Sex:	% male	52.3		58.5	60		58.1
Diagnoses							
Prematurity: %		72.3		80.0	80		76.7
IRDS: %		25.7		24.4	50	*	16.1
Birth Trauma: %		15.4		9.8	0		12.9
Congenital Defects: %		19.6	*	34.1	50		29.0
Hospital Course							
Days in hospital: mean		23.0		31.8	51.9	*	25.3
Days until nipple fed: mean		8.2		12.6	16.1	*	11.6
Days in oxygen: mean		3.8	*	8.8	21.6	*	4.9
Days in isolette: mean		16.6	*	24.2	36.6	*	20.3

*Significant difference between groups

The Children's Hospital Medical Center

300 Longwood Avenue, Boston, Massachusetts 02115, Telephone: (617) 734-6000

April 12, 1977

Senator Alan Cranston
Chairman
Subcommittee on Child
and Human Development
United States Senate
Committee on Human Resources
Washington, D.C. 20510

Dear Senator Cranston:

I am writing to respond to the questions for the expert panel for which there was not time during the testimony on child abuse on April 6, 1977.

I shall address the questions in numerical sequence. I believe that the service provision components of the Bill should indeed require the Department of HEW to replicate programs of demonstrated effectiveness. Simply to pour more resources into existing state child welfare agencies, is, in my view an unproductive use of the small amount of money available in this Bill. There is, of course, also plenty of data to suggest that the states aren't using the money anyway.

My belief is that the main problem with the research conducted on child abuse is that there is not nearly enough of it which addresses the needs of all of the children, rich and poor, white and nonwhite, served by the public and by the private sectors, who are victims of abuse and neglect. Much more research is needed, and I believe that the Act should be changed to emphasize the need for more and better research. At least 75% of the authorization, in my view, should go to research and demonstration activities.

I see no problem in the Government's continuing to provide direct support for training in this field, but, unfortunately, for political reasons there still seems to be an inclination to support training by discipline. This had led, for example, to virtually no training of physicians and other medical workers, and an inadequate addressing of the needs for cross-disciplinary training of social workers. Furthermore, the training materials which have been developed by the National Center to date only treat the identification of child abuse and neglect. Much more work is necessary to create good materials which deal with the treatment, management, and prevention of child abuse and neglect.

I feel that the resource centers created under this legislation are enormously effective, and I believe they should continue to exist. I am

April 12, 1977

Senator Alan Cranston
Chairman
Subcommittee on Child
and Human Development
United States Senate
Committee on Human Resources
Washington, D.C. 20510

Page Two

concerned, however, that the resource centers have been told by the Office of Child Development that they shall certainly have to close by mid-1978. Some interpret this as an effort on the part of the National Center actually to prevent the development of institutionalized competency in this field. This in part derives from the sense of alienation of the staffs of the resource centers from the National Center staff, but I believe it also has to do with the uncertainty of their funding. I think they should definitely be mandated to continue.

As I mentioned in my testimony, I believe that the main criterion for state funding should be a capacity to demonstrate linkages at the local level between child welfare, child development, and child health services. Unfortunately, so incompetent are most of the child welfare bureaucracies and so trivial the amount of money made available to them under the state formula program that there is little incentive for action. I disagree with my colleague Dr. Kempe that much more money should be available to the states under the statute. I really don't think it does any good. And as Dr. Zigler pointed out in his testimony it creates the illusion of a solution to a problem which demands much more in Federal and State commitment.

I think that the existing advisory board on child abuse and neglect, within HEW, has been demonstrably ineffective. It is clear that other agencies have withdrawn their support for child abuse and neglect research and program, and that the OCD is unable to carry out a leadership role. This needs to be addressed in the creation of a new, extra governmental advisory board, and in addressing the status of the Office of Child Development.

If this statute is now renewed for more than a year, it will be unlikely, in my view, that researchers and clinicians of excellence will be attracted to this field. There is no way that good new research can get under way with less than a three year commitment. It took Dr. Richard Gellis seven years to put his study together; it took me five to put mine together. In the absence of the developing national policy on child development, child welfare, child health, and the family, I think it is essential that the support for child abuse work continue for longer than a year. As to the dollar authorization for fiscal 1978 and subsequent years, I personally believe that present levels are far too low to make any difference in developing an adequate knowledge and practice base. I think that the appropriation should be at least doubled, and that the bulk of the expenditure should go to research/demonstration efforts. Only a small fraction of the applications in the original call for proposals were funded.

April 12, 1977

Senator Alan Cranston
Chairman
Subcommittee on Child
and Human Development
United States Senate
Committee on Human Resources
Washington, D.C. 20510

Page Three

I would be happy to work with you and your staff on the development of this and other child development and child health legislation. Please do not hesitate to contact me if I can be of further assistance.

I should also like to say how much I have appreciated the excellent work of Ms. Ellen Hoffman of the Subcommittee Staff. For many of us working in this field, she has been the single ray of hope at times of conflict and despair, and the oversight function of your subcommittee was carried forth brillantly, in my view, in large part because of her persistence, seriousness, great knowledge of the field, and a sense on the part of all concerned of her absolute integrity.

With kind regards,

Sincerely,

Eli H. Newberger, M.D.
Director
Family Development Study

EHN/gf

Fulton County
Department of Family and Children Services
2001 MARTIN LUTHER KING JR. DRIVE S.W.
ATLANTA, GEORGIA 30310

GILBERT G. DULANEY
ADMINISTRATOR
VALLIE D. STATEN
DEPUTY ADMINISTRATOR
ANN JEWETT
PROGRAM DIRECTOR

April 6, 1977

The Honorable Alan Cranston
United States Senator
Senate Subcommittee on Children
and Youth
Washington, D.C. 20510

RE: P. L. 93-247
Child Abuse and Neglect Act

Dear Senator Cranston:

The Fulton County Department of Family and Children Services supports the extension of the above-named law. We very much support the expansion of public law 93-247 for another five years, if not for a longer period. The following points need to be considered in any expansion:

A.1340.3-6 - Grants to States should be raised from 20% to 50% of the funds in order for more funds to flow to the states for the development, strengthening and carrying out of child abuse or neglect prevention or treatment programs, as stated in the law. Without an increase in funds, strengthening existing programs would not be possible.

B.1340.2-1(d) - Research, Technical Assistance and Demonstration should be reduced from 50% to 20% of funds. There should have been ample time to research the problem and demonstrate effective means of delivering services. Throughout this Research and Demonstration Process, very little attempt was made to look at and research already existing child protective services programs. Therefore, funds were wasted by duplication of efforts by failing to recognize earlier achievements and failures. What has been needed all along is more money for social service staff and resources, and this is not forthcoming.

C.Training - Funds are still needed for training of child protective services staff. Training materials of good quality have been developed under this grant. However, the states in turn will have to purchase these materials, hire staff to do training, and provide for travel and per diem. We do not have funds available in the State or local County to provide the necessary intensive training of our staff on a regular basis or to allow for continuing education and orientation for new staff. This situation puts our child protective services staff into a situation where they will be left with limited training resources and the clients will be the ones to suffer in the end.

Senator Alan Cranston
Page #2
April 6, 1977

Research, demonstration projects and public relations campaigns generate all sorts of public concern and outrage at this societal problem, but no one at any governmental level wants to spend any more money at the local levels where the problem is real and there 24 hours a day.

The law, as written, is only a beginning, and if extended "as is" will in no way begin to meet the purpose of the program as stated in 1340.1-1:

> "(a) The basic purpose of this program is to assist States and localities, and non-profit private organizations in carrying out their responsibilities for the protection of children and for the amelioration of their environment, particularly as an integral part of a family unit whose adult member(s) need help in coping with emotional or environmental stresses.
>
> "(b) The main threst of this program effort is to assist States, local and voluntary agencies and organizations to strengthen their capacities to develop programs that will:
>
> > "1) Prevent child abuse and neglect;
> >
> > "2) Identify abused and neglected children; and
> >
> > "3) Provide necessary ameliorative services to them and their families."

We request that the law be extended with recommended changes.

Sincerely,

Anne Jewett
Anne Jewett
County Program Director
Service Division I

AJ/blw

CC: Gilbert G. Dulaney
Vallie D. Staten

American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108
(816) 474-5720

Anne Zimmerman, R.N.
President

Margaret F. Carroll, R.N.
Acting Executive Director

Washington Office:
1030 15th Street, N.W.
Washington, D.C. 20005
(202) 296-8010

April 1, 1977

The Honorable Alan Cranston
Chairman, Subcommittee on Child &
Human Development
Senate Human Resources Committee
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

The American Nurses' Association, through its Division on Maternal and Child Health Nursing Practice, would like to support the extension of P.L. 93-247, the Child Abuse Prevention and Treatment Act. At our June, 1976 biennial convention, the ANA House of Delegates passed a resolution which supports adequate federal funding of child abuse programs, adequate preparation in nursing curriculums for nurses to increase their knowledge and skills in the area of child abuse, the availability of family planning, counseling, prenatal and postpartum services to all people in need of such services, and participation of nurses in the decision making and planning stage of programs relating to child abuse and neglect.

P.L. 93-247 addresses a number of the problems related to child abuse. Many professional nurses are serving on the interdisciplinary teams responsible for activities under this Act. We support an extension of the law, but would like to see some shift in emphasis from data gathering and studies to define the problem to a stronger emphasis on evaluation of prevention techniques, more prevention and treatment programs that actually reach families, and greater interdisciplinary involvement.

We believe that there has been sufficient data gathering and that monies should now be directed towards dealing with the problem. This could include more teams to work with parents, more day-care and crises nurseries, better preparation of nursing, medical and legal professionals, and systems changes to deal with this complex social problem.

An incident reported to us by a Colorado nurse illustrates this need. After her "team" had gone through all the procedures and gotten one child neglect case to court, the children were returned to the family with no requirement for family counseling, further referral to a health facility, or any other provision for follow-up. When the team doctor was asked by the nurse "Why?" -- why bother when no change is going to take place, his answer was, "At least it protects us. When the child arrives dead, the chart will show we tried!" Unfortunately, this is the outcome of a good many court cases.

The American Nurses' Association feels that an interdisciplinary approach to the prevention and treatment of the battering family is mandatory. Nurses, social workers, educators, laypersons and physicians working as a team are a necessity to combat and conquer the child abuse problem. We strongly feel that prevention and treatment of child abuse should be an important concern to all individuals and appreciate the opportunity to comment on this legislation.

Sincerely,

Anne Zimmerman

Anne Zimmerman, R.N.
President

AZ:mw

The Big Sky Country

STATE OF MONTANA
SOCIAL AND REHABILITATION SERVICES
P.O. BOX 4210
HELENA, MONTANA 59601

THOMAS L. JUDGE
GOVERNOR
PATRICK E. MELBY
DIRECTOR

COMMUNITY SERVICES DIVISION
EDWARD MALENSEK
ADMINISTRATOR

May 5, 1977

The Honorable Allen Cranston
U.S. Senate
Chairman Subcommittee on Child &
  Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Cranston:

I am writing to you to request your support of Public Law 93-247 which provides for research and treatment in the difficult area of child abuse and neglect. In my capacity as protective services consultant for the State of Montana, I am well aware of the need for services to prevent child abuse and neglect as well as to meet the rising problem.

I am also encouraging you to relax the rigid criteria for becoming eligible for the grants. You may be aware that Montana has not been able to become eligible. We are, however, very serious about offering quality services to children and their families. Relaxing some of the criteria would allow us to use a grant to improve services and, hopefully, to provide for an attorney for the child in all termination cases.

I further recommend that a greater share of the funding go directly into treatment rather than into research.

Thank you for your support of legislation for children. By working together, we hope to serve children and their families more effectively.

Sincerely,

Gloria Brinkman

Gloria Brinkman, Consultant
Social Services Bureau

GB:ce

SAN FRANCISCO CHILD ABUSE COUNCIL
1304-A CASTRO STREET
SAN FRANCISCO, CALIFORNIA 94114
(415) 647-4578

BOARD OF DIRECTORS
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Letterman Hospital
Helyn Wolff
Nurse Administrator
SF Health Department

Executive Director
James B. Garrison, M.A.

May 6, 1977

Senator Allen Cranston
United State Senate
Washington, D.C. 20510

Dear Senator Cranston:

I am writing to urge you to vote for continuation of the National Child Abuse and Neglect Act. I have been working in this field for about 15 years and am currently President of the San Francisco Child Abuse Council. I hardly need to tell you how serious the problem is in our country. The resources devoted to its control in various communities are really not adequate. While the National Center for Child Abuse has not had problems which are ideal and has not been able to do much in terms of help with treatment services, it has provided a stimulus, considerable information and guidance for those of us who are working in this field.

I think it is important to extend the National Child Abuse and Neglect Act.

Sincerely yours,

Moses Grossman

Moses Grossman, M.D.
President,
Professor of Pediatrics,
University of California, San Francisco

MG:o

State of New Hampshire
DEPARTMENT OF HEALTH AND WELFARE
DIVISION OF WELFARE
8 LOUDON ROAD
CONCORD 03301

May 10, 1977

The Honorable Alan Cranston
United States Senate
Chairman, Subcommittee on Child and Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

I am writing to you to urge your support for reauthorization of Public Law 93-247, The Child Abuse Prevention and Treatment Act

The emphasis since 1974 when Public Law 93-247 was enacted has been in the area of research and demonstration grants with a minimum of support to the states to strengthen child protective services.

After reviewing the testimony for the record in the hearings, as well as having discussed this with my colleagues in other states, I would strongly recommend that 70% of the total appropriation for this act be allocated for distribution to the states to aid them in developing, strengthening and carrying out child abuse and prevention and treatment programs, and that 25% be used for grants to institutions of higher learning and/or to private non-profit agencies for training and/or research in the operation of resource centers and demonstration centers. To emphasize, my recommendation is for grants, not contracts, and to nonprofit organizations rather than to profit-making organizations. With one exception, our experience with contracted agencies in the child abuse/neglect field has been less than satisfactory.

In addition, my recommendation also would include the relaxation of the rigid eligibility criteria which states have been required to meet in order to be eligible for the current funds. Fortunately New Hampshire has met these requirements in the past, but other states have been unable to do so. None of us questions the need for standards, but the rigidity of those responsible to determine eligibility and to which the states were required to adhere I cannot believe was the intent of Congress when the law was passed.

The State of New Hampshire has had a dramatic increase in its reporting law within the past two years, and it is imperative that we develop and maintain the needed services as we face an ever increasing demand for resolution of the problem of child abuse and neglect.

Again, may I request your support in the reauthorization of Public Law 93-247, and thank you in advance for your concern.

Yours sincerely,

Barbara A Hanus

Barbara A. Hanus, ACSW
Chief, Bureau of Child
and Family Services

BAH:s

Live Free or Die

NORTHAMPTON COUNTY CHILDREN'S BUREAU

MAIN OFFICE
2057 Nazareth Rd.
EASTON, PA. 18042
215 [illegible]

BRANCH OFFICE
520 E. Broad St.
BETHLEHEM, PA. 18018
215 [illegible]

R. NANCY HALEY, ACSW
DIRECTOR

May 10, 1977

Honorable Allen Cranston
U.S. Senate
Chairman Sub-Committee on Child &
Human Development
4230 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Cranston:

As Executive Director of the Northampton County Children's Bureau, I would like to urge you to reauthorize Public Law 93-247, the Child Abuse Prevention and Treatment Act. We believe continued funding is needed both for research and direct services in the area of child abuse. Unless the Act is extended, valuable research which is now underway will be jeopardized. We do urge you, however, to relax the criteria which prevent some states from a share in funding which would aid them in developing, strengthening, and carrying out child abuse prevention and treatment programs. We suggest that States qualify for funds by being in substanial compliance of the standards contained in the Act.

You are to be commended for your concern about child neglect and abuse. We hope you will continue to support efforts to protect neglected and abused children by supporting the reauthorization of Public Law 93-247.

Sincerely,

R. Nancy Haley

(Miss) R. Nancy Haley, ACSW
Executive Director

RNH:jhh

SCAN Service, Inc.
(Suspected Child Abuse and Neglect)
P. O. Box 1171
Fayetteville, Ark. 72701

May 13, 1977

Honorable Alan Cranston
U. S. Senate
Washington, D. C. 20510

Dear Senator Cranston:

We strongly support reauthorization of Public Law 93-247, The Child Abuse Prevention and Treatment Act. We urge that the emphasis of the legislation be shifted from research to direct treatment services for children and families. At a recent conference on child abuse in Houston, Judge Polier of New York, a leader in the field, said that we can no longer wait for research results.

There are already child protective service programs in the individual states, all of which need increased funding for further development and improvement of service delivery. Some states, like Arkansas, have incorporated innovative programs, such as SCAN, into their service delivery system. Funds are needed to continue established programs, as well as to incorporate new ideas from the flood of recent research.

We agree with the proposals made by the American Humane Association in their letter of April 28 to you concerning revision of the Act.

Thank you for your efforts on behalf of children.

Sincerely,

Gene Tweraser
Assistant Director
Washington County SCAN

CC: Honorable John McClellan
Honorable Dale Bumpers
Honorable John Paul Hammerschmidt

STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF SOCIAL SERVICES
325 N. SALISBURY STREET/RALEIGH 27611

JAMES B. HUNT, JR.
Governor

SARAH T. MORROW, M.D., M.P.H.
Secretary
Dept. Human Resources

ROBERT H. WARD
Director

IN REPLY REFER TO CODE PCS

April 25, 1977

The Honorable Alan Cranston
Senate Subcommittee on Children and Youth
Senate Building
Washington, D. C. 20515

Dear Senator Cranston:

We welcome the opportunity to comment on the 1974 Child Abuse Prevention and Treatment Act (P.L. 93-247), especially in regard to the extension of funding of regional resource centers. First of all, let me say that we feel fewer funds should be appropriated for demonstration projects and a much higher percentage, sixty percent or above, should be used for grants to states in order to strengthen and expand their child protective services programs.

If this is done, we understand that a major area of concern has to do with coordinating state activities. We would suggest that regional resource centers could fill this role. We recommend that Region IV's resource center in Athens, Georgia be continued, partially using the remainder of the appropriated funding, in order that this coordination be implemented.

While state resource centers, such as the one North Carolina has, are a good idea, we feel it would be more effective and practical to have a regional center, which can pool staff and other resources in one place as well as coordinate a number of the activities of the states in the region. It would be a costly duplication in having state resource centers to accomplish the same purpose.

We hope that these comments are helpful in your consideration of this issue.

Sincerely,

Robert H. Ward

Robert H. Ward

T. M. JIM PARHAM / Commissioner

47 TRINITY AVE., S.W., ATLANTA, GEORGIA 30334

March 15, 1977

The Honorable Alan Cranston
United States Senator
Senate Subcommittee on Children
 and Youth
Washington, D.C.   20510

Re: P.L. 93-247
Child Abuse & Neglect Act

Dear Senator Cranston:

The Georgia Department of Human Resources, Division of Family and Children Services supports the extension of the above law for another five years, if not longer, providing that the following is taken into consideration:

A. 1340.3-6-Grants to States should be raised from 20% to 50% or more of funds to allow more funds to flow to the states "to develop, strengthen, or carry out child abuse or neglect prevention or treatment programs," as stated in the law.

Under the existing law, Georgia is eligible for $84,265 of state grant funds which will be used to provide 24-hour protective services in four counties. If there is no increase in funds, there would be no means to strengthen existing programs beyond this level much less to provide raises for employees hired under this grant.

B. 1340.2-1(d) Research, Technical Assistance and Demonstration should be reduced from 50% to 20% of funds.

There should have been ample time to research the problem and demonstrate effective means of delivering services. Throughout this Research and Demonstration Process, very little attempt was made to look at and research already existing child protective services programs. Therefore, funds were wasted by duplication of efforts by failing to recognize earlier achievements and failures. What has been needed all along is more money for social service staff and resources, and this is not forthcoming under the existing law.

The Region IV office of Child Development has provided excellent technical assistance to Georgia through the Child Abuse and Neglect Specialist who is funded by this Grant. Georgia would support continuation and expansion of the technical assistance at the office of Child Development of the DHEW Regional offices to further coordinate state activities should funding be increased.

C. Training - funds are still needed for training of child protective services staff. Training materials of good quality have been

> developed under this grant. However, the states in turn will have to purchase these materials, hire staff to do training, and provide for travel and per diem. Georgia is a very large state with approximately 600 social service staff and supervisors who provide child protective services in 159 counties. We do not have funds available in the state to provide the necessary intensive training of our own staff on a regular basis to allow for continuing education and orientation for new staff. Nor do we have matching funds to pull in Title XX training money. We have also been told by HEW that our $32,000 training allottment under this law for the next year cannot be used to train our protective services staff but must be used to train and involve other professionals. This puts our own child protective services staff back into a situation where they will be left with the scraps of limited training resources and the clients will be the ones to suffer in the end.

Perhaps the strongest concern related to P.L. 93-247 is that it does too little to benefit those dedicated protective services staff who are responsible for delivering a very necessary service which continues to be overlooked by funding bodies.

Research, demonstration projects and public relations campaigns generate much public concern and outrage at this societal problem, but no one at any governmental level wants to spend any more money at the local levels where the problem is real and there 24 hours a day.

Laws and regulations (i.e., the State Grant eligibility criteria) can be changed but it does not mean a thing to the caseworker who is sitting there with a caseload of 50 families and 150 abused and neglected children that he or she is responsible for protecting, without the time or resources to do the job the state and federal government says is to be done. It is this caseworker who lives with the constant fear that one of these children could die, and the caseworker is held responsible. Or, what help is it for a supervisor who supervises 8 casework staff with up to 1,000 abused and neglected children and lives with the same fear of death a thousand fold. P.L. 93-247 does not respond to these fears by providing money for adequate staff or supervisors or state support to local program development.

The law, as written, is only a beginning and, if extended "as is", will in no way begin to meet the purpose of the program as stated in 1340.1-1:

> "(a) The basic purpose of this program is to assist States and localities, and non-profit private organizations in carrying out their responsibilities for the protection of children and for the amelioration of their environment, particularly as an integral part of a family unit whose adult member(s) need help in coping with emotional or environmental stresses."
>
> "(b) The main thrust of this program effort is to assist State, local and voluntary agencies and organizations to strengthen their capacities to develop programs that will:
>
> 1) Prevent child abuse and neglect;

Honorable Alan Cranston
March 15, 1977
Page Three

2) Identify abused and neglected children; and,

3) Provide necessary ameliorative services to them and their families."

I would welcome an opportunity to present Georgia's concerns at any Subcommittee hearings, based on 13 years experience as a juvenile probation officer and as a protective services caseworker, supervisor, administrative supervisor and consultant.

Very truly yours,

Barbara S. Cundiff

Barbara S. Cundiff, Consultant
Division of Family and Children
Services

BSC:mb

COMMISSIONERS
William M. [illegible]
John F. [illegible]
Carl W. [illegible]

Gary E. Stout, Administrator
Phone [illegible]

CLINTON COUNTY, PENNSYLVANIA

CHILDREN'S SERVICES
COURT HOUSE
LOCK HAVEN, PENNA.

May 2, 1977

The Honorable Allen Cranston
U. S. Senate
Chairman, Sub-Committee on Child and Human Development
4230 Dirkson Senate Office Building
Washington, D. C. 20510

Re: Law 93-247

Dear Mr. Cranston:

As workers in the field of abuse and neglect, we urge that Congress re-affirm its concern for abused and neglected children by re-authorizing Public Law 93-247.

We understand that Dr. Vincent DeFrancis, Director, Children's Division of the American Humane Assoc. has made suggestions to you for modification of funding and distribution of funds in PL 93-247.

We hope that your sub-committee will give careful consideration to his suggestion.

This agency is appreciative of your continuing concern for children.

Sincerely,

Elizabeth M Greiner

(Mrs.) Elizabeth M. Greiner
Caseworker

Gary E. Stout

Gary E. Stout
Administrator

EMG/k

family service association
of atlantic county

[illegible] BLACK HORSE PIKE
WEST ATLANTIC CITY [illegible]
[illegible]
OUTPOST:
ATLANTIC CITY
BELCOVILLE
HAMMONTON

May 6, 1977

Honorable Allen Cranston
A. S. Senate
Chairman Subcommittee on Child and Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Public Law 93-247

Dear Senator Cranston:

As a member of the American Humane Association we are in support of our organizations stand on the extension of the Child Abuse Prevention and Treatment Act; Public Law 93-247. We feel that the recommendations as suggested by the Association to refocus the Act are extremely important. The law as it now stands provides very little directly to those children who need protection and their parents who need treatment. It is very frustrating to those of us in the field who see state laws passed which mandate all kinds of services but then cannot be implemented for lack of funds. If the Child Abuse Prevention and Treatment Act was refocused to provide more funds to states directly for their child abuse programs, we would in fact get more for our tax dollar.

Public Law 93-247 as the Association states was a good beginning since it crystallized on a national scale the problems of many children and their parents. We strongly urge your support for reauthorization of Public Law 93-247

Very truly yours,

A Tuszynski
Ann Tuszynski , ACSW
Director
Family Life Center

cc/ Vincent DeFrancis, JD. Director

MEMBER ATLANTIC COUNTY UNITED WAY

FAMILY SERVICE ASSOCIATION
OF LICKING COUNTY
122 West Church Street
Newark, Ohio 43055
Member Agency United Way

Phone 345-4920

May 5, 1977

Honorable Allen Cranston
U.S. Senate
Chairman Subcommittee on Child and Human Development
4230 Dirksen Senate Office Building
Washington DC 20501

Dear Senator Cranston:

I wish to urge you to support the re-authorization of the Public Law 93-247 and also to refocus on the points made by the American Humane Association in a letter recently sent to you by Vincent DeFrancis. Although our agency is a very small one, we have set the highest priority on creating treatment and prevention programs in the area of child abuse and neglect. I feel that it is absolutely essential to aid the states to develop, strengthen, and implement child abuse prevention and treatment programs.

Sincerely,

FAMILY SERVICE ASSOCIATION

Florence R. Gibson

Florence R. Gibson, ACSW
Executive Director

FRG:pc

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
REGION VII, 1655 South Woodruff, Idaho Falls, ID 83401

May 23, 1977

The Honorable Allen Cranston
United States Senate
4230 Dirksen Senate Office Building
Washington D.C. 20510

RE: P.L. 93-247

Dear Senator Cranston:

I am writing to you in support of the comments regarding P.L. 93-247 sent to you by the American Humane Association dated April 28, 1977.

While I recognize the need for continuing research and development of new concepts in the area of prevention of child abuse and neglect, I am also acutely aware of the need for additional funding for existing programs which are already attempting to alleviate the plight of countless numbers of children. Therefore, I would urge your consideration of a refocusing of the intent of P.L. 93-247 to include allocations for the existing programs to increase their effectiveness and to expand their capability in dealing with abused and neglected children.

Sincerely yours,

David H Groberg

David H. Groberg, Ph.D.
Regional Director

DHG:sc

County of Durham
Department of Social Services

DANIEL C. HUDGINS
DIRECTOR

P. O. BOX 810
DURHAM, NORTH CAROLINA 27702

June 8, 1977

The Honorable Allen Cranston
United States Senate Chairman
Subcommittee on Child and
Human Development
4230 Dirkson Senate Office Building
Washington, D. C. 20751

Dear Senator Cranston:

It has recently been brought to my attention that your subcommittee is considering the extension of Public Law 93-247, the Child Abuse Prevention and Treatment Act. As the Director of a local agency mandated to provide protective services to children, the extension of this Act under some proposed revisions indicated below, would be a great assistance.

In considering the extension of this Legislation I would propose several changes.

1) That a greater amount of the funds be made available for the purpose of direct service as opposed to research. I would recommend that a certain percentage, but at least 75%, be appropriated and allocated to individual states for the purpose of providing direct child abuse prevention and treatment programs.

2) That the authorization of funds under this Act be increased and that these funds be specifically "earmarked" for the direct support of child protective services at the state and local level. Currently, funding for these services are provided through Title XX of the Social Security Act and the current sealing does not permit sufficient funding in states to provide this and the other services authorized under this title. Experience has shown that in order to treat human needs consistently, funds need to be earmarked for specific purposes such as mental health, retardation, day care, etc.. Congress has not sufficiently funded Title IV-B of the Social Security Act for child welfare services and this lack of funding has prevented many states from meeting the increasing demands for services related to child neglect and abuse.

3) There should be a relaxation in the rigid standards which have been adopted by which states qualify for funding under this Act. The current standards prevent many states from qualifying for funding under this Act and it seems that a relaxation of the standards would benefit more children in states who desperately need funding for treatment and prevention programs.

The Honorable Allen Cranston
Page Two
June 8, 1977

Your continuing support of the efforts to improve child abuse and neglect programs is appreciated. We would urge the continuation of Public Law 93-247 with the above mentioned changes.

Your consideration is appreciated.

Sincerely,

Daniel C. Hudgins, ACSW
Director

DCH/jbm

cc

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 WEST JEFFERSON • PHOENIX, ARIZONA • P. O. BOX 6123 85005

JOHN L. HUERTA
DIRECTOR

JUN 15 1977

Reply to
Attn. of: POD/SSB

The Honorable Allen Cranston
United States Senate
Chairman, Subcommittee on Child and
  Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

Your support of the reauthorization of Public Law 93-247, The Child Abuse Prevention and Treatment Act, is strongly urged.

The intent of Public Law 93-247 addresses the needs of children who have been neglected and/or abused. Arizona is experiencing an increase in the number of children reported to be in need of protection.

The Act would better meet the needs of children were the major portion of funds allocated to the states for the purpose of aiding in developing, strengthening and carrying out child abuse prevention and treatment programs.

Perhaps some of the current problems in the implementation of The Child Abuse Prevention and Treatment Act could be averted by allocating monies for grants, rather than contracts, to institutions of higher learning or to private, non-profit organisations for the conduct of training and/or research in the operation of resource centers and demonstration projects.

Thank you for your support of Public Law 93-247, The Child Abuse Prevention and Treatment Act, to help meet the needs of abused and neglected children.

Sincerely,

John L. Huerta

cc:
Vincent De Frances
5351 S. Roslyn Street
Englewood, Colorado 80110

COUNTY of HIDALGO

CHILD WELFARE UNIT

EDINBURG, TEXAS

COURT HOUSE — ROOM [illegible] — PHONE [illegible] - EXT. [illegible]

May 10, 1977

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Honorable Allen Cranston
U.S. Senate
Chairman Subcommittee on Child and Human Development
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Cranston:

As a worker in the field of child abuse and child neglect, I strongly urge your support for reauthorization of Public Law 93-247. As you know child abuse and child neglect is no respector of nationality, ethic group, age, income group or educational achievement group. And especially child abuse is definately not a respector of political idiology. Child abuse and child neglect is a growing problem and it can not be handled without support of legislation that enhances services to these children and their parents. Therefore I again respectfully urge you support regarding Public Law 93-247.

Sincerely,

Sonja L. Arredondo
(Miss) Sonja L. Arredondo
Masters of Social Work
Administrative Supervisor for
Hidalgo County Child Welfare

SLA/lr

cc: File

THE UNIVERSITY OF WISCONSIN–MILWAUKEE/P.O. Box 413, Milwaukee, Wisconsin 53201
SCHOOL OF SOCIAL WELFARE

June 14, 1977

Senator Alan Cranston
Chairperson, Subcommittee on Child and Human Development
U.S. Senate
Washington, D.C. 20510

Dear Senator Cranston: RE: Support for S 961

This is to encourage your support for the extension of PL 93-247, the Child Abuse Prevention and Treatment Act, as proposed in S 961.

To be cost effective, the Act must be extended for at least two more years. The provisions of S 961 are superior to the provisions for extension in HR 6693.

In particular, we applaud the Senate bill because it provides for continuation of projects which are national or regional in scope. As the Resource Center serving HEW Region V, we know that our own program and the other regional resource centers will be cost effective to the extent that they can be maintained.

To assist you in evaluating what the Midwest Parent-Child Welfare Resource Center has accomplished, I am enclosing a summary from the continuation funding proposal narrative for FY 1977-78.

If you wish additional data or have questions about our program, I would be pleased to respond. My telephone number is (414) 963-4184. Meanwhile, I urge your support for S 961.

Sincerely,

Adrienne A. Haeuser

Adrienne A. Haeuser
Director

AAH:md

enc.

MIDWEST PARENT-CHILD WELFARE RESOURCE CENTER

CENTER FOR ADVANCED STUDIES IN HUMAN SERVICES
(414) 963-4657

Social Service Department

R. E. Jornlin
Director

Please reply to:
2401 Stanwell Drive, rm. 200
Concord, California 94520
(415) 671-4100

Contra
Costa
County

Contra Costa County
Human Resources Agency
Health · Medical · Social Service
Claude L. Van Marter
Director

May 25, 1977

Alan Cranston, U.S. Senate
Chairman of the Subcommittee on
Child & Human Development
4230 Derksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Cranston:

We urge that Congress reaffirm its concern for neglected and abused children by reauthorization of Public Law 93-247. This law has made strides in the areas of: 1) information clearing house, 2) studies on child neglect and abuse, and 3) development of Prevention & Treatment Programs. However, the current allocation (5-20%) should be changed so that approximately 70% would be available for direct services. We recognize that this is a turnabout in emphasis but believe it is necessary to strengthen child protective services throughout the country.

We are also aware of the constraints that have been placed on the States due to the inadequacy of the Title IVB funds appropriated to the States for child welfare services. This has resulted in a lack of support for services desperately needed to meet the rising incidents of child abuse and neglect. An increase of at least ten times the current appropriation, as recommended by the American Humane Association, would provide funds needed to implement much-needed child protective services. We urge your support for reauthorization of Public Law 93-247 and hope that the suggestions mentioned here will be incorporated in order to improve the services to children who may be abused and neglected.

Sincerely yours,

Robert E. Jornlin

Robert E. Jornlin, Director

REJ:RM:mm

CHILD CARE SERVICE
FRONT AND ORANGE STREETS
MEDIA, PENNSYLVANIA 19063
891-2981

DELAWARE COUNTY COUNCIL
FAITH RYAN WHITTLESEY
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DIRECTOR
CHARLOTTE L. HAMMELL

June 9, 1977

Honorable Allen Cranston
U. S. Senate
Chairman Subcommittee on
Child and Human Development
4230 Dirksen Senate Office Building
Washington, D. C. 20510

My dear Senator Cranston:

This will confirm our endorsement of the position of American Humane Society in regard to re-authorization of Public Law 93-247.

We are a public Child Welfare Agency - with official responsibility for abused and neglected children. The present laws do not fully support our protection of the children who are the victims of violence and abuse.

I am enclosing copy of the statement of the American Humane Society which we fully endorse.

Sincerely yours,

Charlotte L Hammell

Charlotte L. Hammell

CLH:mvg
Enclosure

RIVERSIDE COUNTY
DEPARTMENT OF PUBLIC SOCIAL SERVICES

Paul R. Wiley, Director

George H. Christian, Assistant Director

REFER REPLY TO:

Main Office
— 4080 Lemon St.
Riverside, CA 92501

— 135 N. Alessandro Rd.
Banning, CA 92220

— 742 Beaumont Ave.
Beaumont, CA 92223

— 263 N. Broadway
Blythe, CA 92225

— 505 South Buena Vista
Corona, CA 91720

— 247 E. Tahquitz-McCallum Way
Palm Springs, CA 92262

— 117 S. Langstaff St.
Lake Elsinore, CA 92330

— 880 No. State
Hemet, CA 92343

— 46-075B Jackson St.
Indio, CA 92201

— 135 N. "D" St.
Perris, CA 92370

— 5575 Mission Blvd.
Rubidoux, CA 92509

May 6, 1977

Senator Alan Cranston
Suite 452, Russell Senate
Office Building
Washington, D.C. 20510

Dear Senator Cranston:

Public Law 93-247 speaks to the nation's concern for children suffering neglect and abuse. I urge you to support its reauthorization and further recommend that consideration be given to a change in emphasis of the law, as outlined in the attached letter from Vincent De Francis, J.D., Director of the Children's Division of the American Humane Association.

Sincerely,

Paul R. Wiley
Paul R. Wiley, Director

PRW:lk

Attachment

State of Illinois
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

State Administrative Offices • ~~622 East Adams Street~~ • Springfield, Illinois 62706
#1 North Old State Capitol Plaza

July 8, 1977

Senator Alan Cranston
Chairperson, Subcommittee on Child and Human Development
U.S. Senate
Washington, D.C. 20510

Dear Senator Cranston:

I am writing to encourage your support for the extension of PL 93-247, the Child Abuse Prevention and Treatment Act, as proposed in S 961.

While I believe strongly that Federal legislation should encourage and support local level programs, so also do I believe legislation should encourage and support regional and national programs. Thus, I am pleased that S 961 specifically provides for continuation of regional programs, as our experience with the Midwest Parent-Child Welfare Resource Center in Milwaukee has been most positive and beneficial.

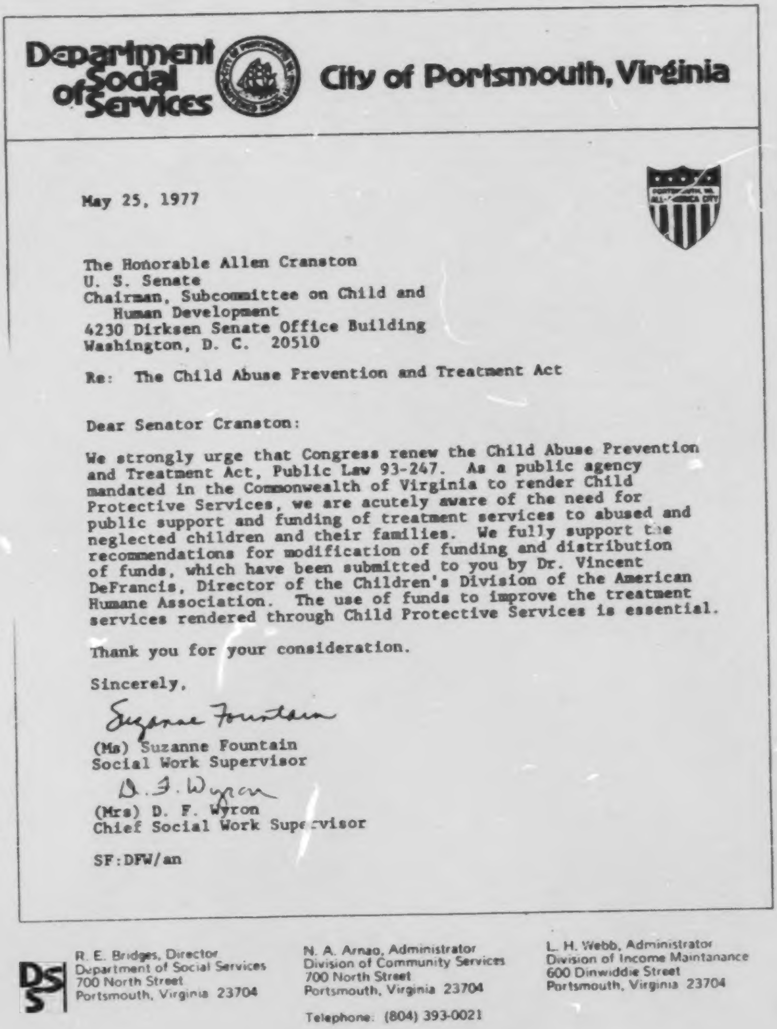
S 961 is also encouraging in that it calls for the addition of three public members to the National Center Advisory Committee. Inclusion of such members is extremely important and overdue.

Again, I urge your support for S 961. If you desire additional information, please contact me.

Sincerely,

Dolores B. Reid
Dolores B. Reid, ACSW
Deputy Director
Program Support Services

DBR/A39c



Department of Social Services
City of Portsmouth, Virginia

May 25, 1977

The Honorable Allen Cranston
U. S. Senate
Chairman, Subcommittee on Child and
Human Development
4230 Dirksen Senate Office Building
Washington, D. C. 20510

Re: The Child Abuse Prevention and Treatment Act

Dear Senator Cranston:

We strongly urge that Congress renew the Child Abuse Prevention and Treatment Act, Public Law 93-247. As a public agency mandated in the Commonwealth of Virginia to render Child Protective Services, we are acutely aware of the need for public support and funding of treatment services to abused and neglected children and their families. We fully support the recommendations for modification of funding and distribution of funds, which have been submitted to you by Dr. Vincent DeFrancis, Director of the Children's Division of the American Humane Association. The use of funds to improve the treatment services rendered through Child Protective Services is essential.

Thank you for your consideration.

Sincerely,

Suzanne Fountain
(Ms) Suzanne Fountain
Social Work Supervisor

D. F. Wyron
(Mrs) D. F. Wyron
Chief Social Work Supervisor

SF:DFW/an

DSS
R. E. Bridges, Director
Department of Social Services
700 North Street
Portsmouth, Virginia 23704

N. A. Arnao, Administrator
Division of Community Services
700 North Street
Portsmouth, Virginia 23704

Telephone: (804) 393-0021

L. H. Webb, Administrator
Division of Income Maintanance
600 Dinwiddie Street
Portsmouth, Virginia 23704

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
HARRISBURG

FRANK S. BEAL
SECRETARY

TELEPHONE NUMBER
787-2600, 787-3600
AREA CODE 717

May 27, 1977

Honorable Allen Cranston
U. S. Senate
Chairman Subcommittee on Child and
  Human Development
4230 Dirksen Senate Office Building
Washington, D.C.   20510

Dear Mr. Cranston:

This letter is in support of Public Law 93-247 more commonly referred to as the Child Abuse Prevention and Treatment Act of 1974. Congress is certainly to be commended for passing this law and should be urged to reauthorize P.L. 93-247 as testimony of their continued concern for the plight of abused and neglected children in the United States.

This is the first such law that made money specifically available to begin to deal with this serious social problem. I submit the following recommended changes which I feel, if included, would continue to improve services to abused children and their families.

I suggest that the focus be shifted from a strong emphasis on research and development to the expansion and development of programs that provide treatment directly to abused children and their parents. Presently the appropriated money has been used to explore the problems and train the many professions that deal with the problem of child abuse. It is now time to funnel funds into strengthening and developing treatment programs.

Second, Congress is to be commended for their effort to assist children by establishing standards for states to meet before being eligible for funds. However, because these standards are so high and not met by all states it did not have the effect of helping as many children as it might have. What I recommend is that the legislation continue to set standards but more in line with meeting the needs of states. Consequently, more states will be eligible for funds.

I am hopeful that Congress will reauthorize this act as it is the first attempt to specifically address the problems of abuse and neglect. Pennsylvania alone has realized an increase of 125% in the number of reports of suspected child abuse in less than nine months in 1976.

Thank you for your attention to this request. If there is anything additional I can do to assist you in this request please feel free to contact me.

Very truly yours,

Frank S. Beal

Frank S. Beal

BOARD OF NORTH DAKOTA
State Capitol

United States Senate

ashington, D. C., March 2, 1977

Respectfully referred to

Chairman
Subcommittee on Children and
  Youth
Human Resources Committee
U.S. Senate
Washington, D. C. 20510

Dear Mr. Chairman:

Enclosed is a letter I have received in support of PL 93-247, the Child Abuse Prevention and Treatment Act. I would much appreciate your making this a part of the record when your subcommitee takes up an extension of this law.

With kind regards, I am

Sincerely,

Quentin N. Burdick, U.S.S.

SOCIAL SERVICE BOARD OF NORTH DAKOTA

State Capitol
BISMARCK, NORTH DAKOTA 58505

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ECONOMIC ASSISTANCE
[illegible], Director

VOCATIONAL REHABILITATION SERVICES
[illegible], Executive Director
Box [illegible] - [illegible] North Third Street

FEB 22

February 18, 1977

The Honorable John Brademas, Chairman
Subcommittee on Select Education
Committee on Education and Labor
2178 Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

RE: Hearing on Extension of
42USCA 5101-6
Child Abuse and Prevention and
Treatment Act (PL 93-247)

Dear Representative Brademas:

The Social Service Board of North Dakota recommends renewal of Public Law 93-247, the Child Abuse Prevention and Treatment Act, and accompanying appropriations.

This recommendation is based on our experience with the Region VIII Child Protection Specialist for the Office of Child Development, Dolores Meyer; Regional VIII Training and Technical Assistance Center, the National Center for Prevention and Treatment of Child Abuse and Neglect; and our receipt of state grants under 42USCA 5103 (b) in 1975 and 1976.

The grants received by the Community Services Division, Social Service Board of North Dakota have funded the state's first full-time Child Protection Services Supervisor. In addition, the grants have enabled us to disseminate public information on abuse and neglect, conduct specialized training about abuse and neglect, purchase training materials, begin a State Interagency Task Force on Abuse and Neglect, and enter into a project on court referrals of abuse cases. Child Protection multidisciplinary interagency teams have also begun in five regions and several counties in North Dakota.

Section 5103 (b) (2) (A-J) sets forth state eligibility requirements necessary for the receipt of state grants. We are in concurrence with these criteria. Many of them were incorporated into the North Dakota Century Code 50-25.1 by our Legislature, effective July 1, 1975. This law provided a statutory base for child abuse and neglect and enabled the Social Service Board of North Dakota through the Community Services Division and County Social Service Boards to implement programmatic changes and improve the service delivery to abused and neglected children and their families.

Section 5103 (b) (1), of the Act outlines appropriations for state grants to be not less than five percent and not more than 20 percent. It is our recommendation that the percentage of funds allotted under state grants should be increased to a minimum of 50 percent when the Act is renewed. With the change in North Dakota's Child Abuse and Neglect Reporting Act, reports received by Community Services Division for abuse increased from 127 in the ten year period July 1, 196 through June 30, 1975 to 767 Child Abuse and Neglect Reports during the one year period July 1, 1975 through June 30, 1976. The direct service and case supervision staff of the Division and the County Social Service Boards did not increase proportionately with that number of reports. Therefore, if more funding were allowed in state grants, it would be used to temporarily supplement our present staff until additional positions are made available through the North Dakota State Legislature. The staff could serve to meet the increased need for receipt of reports, investigations thereof, and monitoring of reports of abuse and neglect. A primary concern is that of provisions of appropriate counseling and treatment services to cases brought to light through our reporting act.

North Dakota has appreciated the publications prepared and dispensed through the National Center on Child Abuse and Neglect in Washington, such as "Planning and Implementing Child Abuse and Neglect Service Programs", "Federally Funded Child Abuse and Neglect Projects, 1975", "Child Abuse and Neglect: The Problem and Its Management" (3 volumes), "Diagnosis Process and Treatment Programs", and "Working with Abusive Parents". These materials were shared with us through our Region VIII Office of Child Development Child Protection Specialist.

We have also used our Regional VIII Center, The National Center for Prevention and Treatment of Child Abuse and Neglect in Denver, to provide faculty for in-state training, to obtain training materials, and for child protection team training. Section 5103 (a) (2) provided for the establishment and maintenance of this Center to serve North Dakota and other Region VIII states. In addition, Section 5101 (a) provides for the establishment of the National Center on Child Abuse and Neglect in Washington to compile and publish current research. We commend the Center in its efforts toward this goal. However, it is our impression that public awareness material, the National Center training curriculum and materials, and the incident study are all moving at a slower pace than the development of our own protective service program in our state.

We are concerned that any revisions with the renewal of Public Law 93-247 would not jeopardize North Dakota's current eligibility for state grants. We wish to continue utilizing federal funds for further developing, strengthening and carrying-out of child abuse and neglect prevention and treatment programs.

Thank you for this opportunity to comment on effective legislation which has enhanced federal and state cooperation in protecting children.

Sincerely yours,

T. N. Tangedahl

T. N. Tangedahl, ACSW
Executive Director

cc: Honorable Arthur A. Link
Honorable Milton R. Young
✓Honorable Quentin N. Burdick
Honorable Mark Andrews
Francis Ishida, Deputy Regional Commissioner, Region VIII, HEW
Edward Y. Okazaki, Asst. Regional Director, OCD, Region VIII
Edward T. Weaver, Executive Director, APWA, Wash., DC

III. BACKGROUND MATERIALS

HARRISON A. WILLIAMS, JR., N.J., CHAIRMAN
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S. I. HAYAKAWA, CALIF.

United States Senate
COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

March 25, 1977

Honorable Arabella Martinez
Assistant Secretary for Human Development
Department of Health, Education,
and Welfare
Washington, D. C.

Dear Arabella,

I understand that you will probably be the Department witness on the proposed extension of the Child Abuse Prevention and Treatment Act at our Subcommittee hearing on April 7.

As you know, Congressional budget deadlines require that legislation entailing fiscal year 1978 spending must be reported from Committee by May 15, 1977. In order to expedite the process of compiling information needed by the Subcommittee and Committee to take legislative action, I request that you submit the following information by April 5:

(1) A list of the states which have qualified for funding under section 4(b) of the Act.

(2) A list of the states which are qualified for funding on a "provisional" basis, and an indication of why each is not considered to be fully qualified.

(3) A brief summary of how the funds distributed under section 4(b) of the Act have been spent by each recipient state.

(4) A state-by-state accounting of funds received by each eligible state in each fiscal year; and an indication of what amount of the funds allocated in each fiscal year has been spent to date.

Thank you for your cooperation with the Subcommittee.

With best wishes,

Sincerely,

Alan Cranston

Alan Cranston
Chairman
Subcommittee on Child and
Human Development

cc: Honorable Dick Warden

The Honorable Alan Cranston
Chairman
Subcommittee on Child and Human
  Development
United States Senate
Washington, D.C. 20510

Dear Senator Cranston:

This is in response to your letter of March 25, 1977, in which you request certain information concerning state grants under P.L. 93-247.

I am enclosing specific answers to the four questions you asked. I hope they are sufficient. If I can provide any further information, please do not hesitate to call on me.

Sincerely,

/s/

Arabella Martinez
Assistant Secretary for
  Human Development

cc:
NCCAN: Chron. Rdg.
Besharov
FFerro
AMartinez
SRosoff

DJB/ajl/4-4-77

Enclosures

QUESTION 1: A list of the states which have qualified for funding under section 4(b) of the Act.

ANSWER: The following is a list of eligible states by fiscal year. Conditional grants are indicated by an asterisk:

FY '74

Hawaii
New York
Tennessee

FY '75

Arkansas
Maine
Missouri
Oklahoma
Utah
Virginia
Illinois
Minnesota
New Hampshire
North Dakota
Vermont
Connecticut
Massachusetts

FY '76

Rhode Island
Puerto Rico
New Jersey*
Alabama
Georgia
Michigan*
Texas*
Louisiana*
Kansas
South Dakota
California
Washington*
Delaware*

QUESTION 2: A list of the states which are qualified for funding on a "provisional" basis, and an indication of why each is not considered to be fully qualified.

ANSWER: The following States have received conditional grants subject to the submission of documentation establishing their full eligibility:

New Jersey
Delaware
Michigan
Texas
Louisiana
Washington

Attached are the state-by-state reasons for the conditional award.

NEW JERSEY

The release of FY 1976 funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and the Central Office of the Office of Child Development, satisfactory documentation that:

1. The State definition of "child abuse and neglect" is in accordance with all aspects of the definition of "child abuse and neglect" found in 45 CFR 1340.1-2(b)(1)-(3).

2. The State provides for mandatory reporting by some persons and permissive reporting by all other persons of known or suspected instances of child abuse and neglect to a properly constituted authority with the power and responsibility to perform an investigation and take necessary ameliorative and protective steps as required in paragraph (d)(3) of s1340.3-3.

3. The State provides that the reporting referred to in 45CFR 1340.3-3(d)(2)(i) must be to an agency other than the agency, institution, or other facility involved in the acts or omissions, if the report of child abuse and neglect involves the acts or omissions of a public or private agency or other institution or facility.

4. The State provides that, upon a finding of abuse or neglect, immediate steps are taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.

5. The State provides by law for the preservation of the confidentiality of all records concerning reports of child abuse and neglect in order to protect the rights of the child, his parents or guardians.

6. The State provides for the cooperation of law enforcement officials, courts of competent jurisdiction, and all appropriate State agencies providing human services in relation to preventing, identifying, and treating child abuse and neglect.

Delaware

The release of FY 1976 funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and the Central Office of the Office of Child Development, satisfactory documentation that:

1. The State definition of "child abuse and neglect" is in accordance with all aspects of the definition of "child abuse and neglect" found in 45 CFR 1340.1-2(b)(1)-(3).

2. The State provides that, upon a finding of abuse or neglect, immediate steps be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.

3. The State has in effect throughout the State, such administrative procedures, such trained personnel, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary to assure effective enforcement of the child abuse and neglect laws, specifically including: provision for the receipt, investigation, and varification of reports; provision for the determination of treatment or ameliorative social service needs; provision of such services; and, when necessary, resort to criminal or juvenile court.

4. The State provides by law for the preservation of the confidentiality of all records concerning reports of child abuse and neglect in order to protect the rights of the child, his parents or guardians.

5. The State insures, to the extent feasible, that parental organizations combating child abse and neglect, as recognized by the State, received preferential treatment.

In addition the release of funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and Central Office of the Office of Child Development a resubmission of an acceptable program narrative (Part IV of the application.)

Michigan

The release of FY 1976 funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and the Central Office of the Office of Child Development, satisfactory documentation that:

1. The State provides that the reporting referred to in 45CFR 1340.3-3(d)(2)(i) must be to an agency other than the agency, institution, or other facility involved in the acts or omissions, if the report of child abuse and neglect involves the acts or omissions of a public or private agency or other institution or facility.

2. The State provides that, upon a finding of abuse or neglect, immediate steps are taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.

3. The State provides that in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem is appointed to represent the child in such proceeding.

Texas

The release of FY 1976 funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and the Central Office of the Office of Child Development, satisfactory documentation that:

1. The State definition of "child abuse and neglect" is in accordance with all aspects of the definition of "child abuse and neglect" found in 45 CFR 1340.1-2(b)(1)-(3).

2. The State provides for mandatory reporting by some persons and permissive reporting by all other persons of known or suspected instances of child abuse and neglect to a properly constituted authority with the power and responsibility to perform an investigation and take necessary ameliorative and protective steps as required in paragraph (d)(3) of s1340.3-3.

3. The State provides by law for the preservation of the confidentiality of all records concerning reports of child abuse and neglect in order to protect the rights of the child, his parents or guardians.

4. The State provides that in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem is appointed to represent the child in such proceeding.

Louisiana

The release of FY 1976 funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and the Central Office of the Office of Child Development, satisfactory documentation that:

1. The State definition of "child abuse and neglect" is in accordance with all aspects of the definition of "child abuse and neglect" found in 45 CFR 1340.1-2(b)(1)-(3).
2. The State provides that the reporting referred to in 45CFR 1340.3-3(d)(2)(i) must be to an agency other than the agency, institution, or other facility involved in the acts or omissions, if the report of child abuse and neglect involves the acts or omissions of a public or private agency or other institution or facility.
3. The State provides that, upon a finding of abuse or neglect, immediate steps are taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.
4. The State provides that in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem is appointed to represent the child in such proceeding.
5. The State provides that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds has not been reduced below the level provided during Federal fiscal year 1973.
6. The State sets forth policies and procedures designed to assure that Federal funds made available under this Act, for any fiscal year, will be so used as to supplement, and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects.

Washington

The release of FY 1976 funds to the grantee is conditional on the receipt and approval, by the appropriate HEW Regional Office and the Central Office of the Office of Child Development, satisfactory documentation that:

1. The State definition of "child abuse and neglect" is in accordance with all aspects of the definition of "child abuse and neglect" found in 45 CFR 1340.1-2(b)(1)-(3).

2. The State provides for mandatory reporting by some persons and permissive reporting by all other persons of known or suspected instances of child abuse and neglect to a properly constituted authority with the power and responsibility to perform an investigation and take necessary ameliorative and protective steps as required in paragraph (d)(3) of s1340.3-3.

3. The State provides that the reporting referred to in 45CFR 1340.3-3(d)(2)(i) must be to an agency other than the agency, institution, or other facility involved in the acts or omissions, if the report of child abuse and neglect involves the acts or omissions of a public or private agency or other institution or facility.

4. The State provides that upon receipt of a report of a known or suspected instance of child abuse or neglect an appropriate investigation is initiated promptly by a properly constituted authority to substantiate the accuracy of the report.

5. The State provides that, upon a finding of abuse or neglect, immediate steps are taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.

6. The State provides that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds has not been reduced below the level provided during Federal fiscal year 1973.

QUESTION 3: A brief summary of how the funds distributed under section 4(b) of the Act have been spent by each recipient state.

ANSWER: Alabama

Funds are used to implement a beeper signaling system in all 67 county departments. The beepers enable workers to be contacted while in the field and after hours so that 24 hour protective service coverage will be provided. In 25 counties a child abuse reporting line and answering service will also be provided.

Arkansas

Funds are used to hire four people to redesign the Central Register, initiate a hotline and after-hours answering service, and develop baseline data.

California

Funds will be used to establish an Office of Child Abuse Prevention in the Social Services Division of the State Department of Health. Pilot projects will be initiated and directed towards identification, treatment, making use of volunteers for 24 hour placement services, day care, training for professionals and parents and special classes for children.

Connecticut

Funds are being used to initiate a program of standby protective services to cover non-working hours. A total of seven positions will be created to give standby services during the hours of 4:30 p.m. to 11:30 p.m. on weekdays and from 10:00 a.m. to 10:00 p.m. on weekends and holidays.

Georgia

Funds will be used to staff five positions in order to establish 24 hour emergency services in four counties.

Hawaii

A social worker was hired to provide intake service on child abuse and neglect cases and a protective services public information specialist was employed to develop and implement community education program.

Illinois

Funds are used to improve and extend Emergency Protective Services in Chicago, thus allowing the city to maintain a 24 hour response capability.

Kansas

Funds are used to fund local programs and demonstration projects.

Louisiana

Funds will be used by the State for training and consultative workshops, purchase of equipment and resource materials.

Maine

Funds are used to support a Comprehensive Emergency Service in Kennebec county. The CES project will fund new child protective services at the community level, i.e., emergency homemakers, caretakers, and foster care.

Massachusetts

Funds are used to assess the effectiveness of existing services, identify gaps in services, mobilize other public and private resources to become involved in child abuse and neglect and organize local citizen groups to become involved in child abuse and neglect.

X **Michigan**

Funds will be used for a shelter home and primary prevention project. Infants at risk are identified through prenatal care health screening and pediatric care. Remedial services will be provided by public health and other social agency staff and coordinated by a specially trained mental health interventionist.

Minnesota

Funds are used for two staff positions. One position serves as an interdepartmental coordinator of child abuse and neglect programs and the other as a resource for developing educational components for professionals and for public awareness.

Missouri

Funds are used for extensive public education on a Statewide basis for the provision of a research consultant.

New Hampshire

Funds are used to support three staff positions to the protective services department in the district office in Cheshire county. One position is used for an educator of casework aides, homemakers and day care mothers. The other two positions will be used as social workers who will carry out the proposed service delivery plan and provide supportive services to the family.

New Jersey

Funds will be used to create six staff positions for the purposes of training CPS workers in identification, client relations, acquaint them with services that are available to child abuse and neglect families, and the rights and responsibilities of parents.

New York

The bulk of the funds are used for a demonstration project in New York City. Among the services provided by this project are casework and group work, lay surrogates, psychiatric and psychological evaluation and consultation, and 24 hour access to staff for a parent in crisis. Services made available to the project by purchase include day care, homemaker, legal assistance, family planning, crisis nursery, housing, employment and recreational services.

Funds are also used to continue staffing for technical assistance to localities.

North Dakota

Funds are used to support one staff position for coordinating all State child abuse and neglect activities. Grant funds will also be used for printing professional brochures and to provide educational workshops.

Oklahoma

Funds are used to develop an intradisciplinary Child Abuse and Neglect Committee within the Children's Memorial Hospital. The Committee staff will include members from the departments of: Pediatrics, Radiology, Family Medicine, Nursing Services and Social Services.

Puerto Rico

Funds are used for three staff positions in a referral unit for child abuse and neglect programs. The unit makes preliminary determinations and evaluations in reported cases.

Rhode Island

Funds are used for an Injury Control Unit within the CPS units. Two social workers serve as Injury Control specialists and a Social Service Analyst provides an accurate reporting and statistical system for the CPS unit.

South Dakota

Funds are used for two staff positions in a new public awareness program. Objectives will be media saturation, education of all mandated reporting sources, training capsules for colleges, nursing schools, medical colleges, law schools and the police academy.

Tennessee

Funds are used to support 16 caretakers and 30 homemakers in order to facilitate the implementation of a Comprehensive Emergency Services System, including 24 hour emergency intake.

Texas

Funds will be used to support nine staff positions in order to close gaps in existing protective services to intact families.

Utah

Funds are used for staff to develop a State Office for Child Abuse and Neglect. A portion of the funds are used to provide for the services of a pediatrician to aid the Division in identification, diagnosis and treatment.

Vermont

Funds are used to provide for the services of a clinical psychologist and social worker. Funds are also used for training field staff and for public education materials.

Virginia

Funds are used for a hotline and an additional staff position in the Bureau of Child Protective Service.

Washington

Funds will be used to hire staff to design and implement an information system that will be capable of program monitoring, program planning and program evaluation.

Colorado

Colorado used its grant funds for developing and implementing, in rural counties, multi-disciplinary Child Protection Teams and parent self-help groups.

Delaware

Funds will be used to provide homemaker support services, supportive parent education to improve parenting skills, and emergency in-home care and supervision for children in the temporary absence of the parents.

QUESTION 4: A state-by-state accounting of funds received by each eligible state in each fiscal year; and an indication of what amount of the funds allocated in each fiscal year has been spent to date.

ANSWER: Please see attached chart.

You will note large amounts of unexpended funds. This is accounted for by:

(1) the inability of States to initiate projects promptly because of the limitations of state civil service requirements, (2) the fact that some states changed program plans after being funded, (3) the fact that programs often were delayed until the start of the next State Fiscal Year, and (4) the fact that in some States a legislative appropriation of the grant funds was necessary before the project commence.

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	FY 197[illegible] GRANT	FY 1976 [illegible] PROJ YR		TOTAL ALL AWARDS	TOTAL EXPENDED
[illegible]					170,55[illegible]	30,000		143,50[illegible]	32,[illegible]
[illegible]					89,735	4[illegible],930		89,735	25,900
[illegible]				[illegible]	297,476	[illegible]9,000		215,556	117,000
[illegible]			[illegible]	[illegible]	69,04[illegible]	14,000		82,056	27,015
[illegible]					57,529	6,000		57,529	6,000
Vermont			27,[illegible]	71,[illegible]	61,51[illegible]	[illegible]4,000		73,616	45,900
REGION II									
New Jersey									
New York	[illegible]	[illegible]	[illegible]	-0-	140,743	-0-	Conditional	Award. Funds	not released.
Puerto Rico					239,88[illegible] *	-0-		352,303	32,472
Virgin Islands					117,46[illegible]	9,929		117,462	9,929
REGION III									
Delaware									
Dist. of Col.					27,50[illegible]	-0-	Conditional	award. Funds	not released.
Maryland									
Pennsylvania									
Virginia			39,760	39,760	136,903	81,000		196,663	140,700
West Virginia									
REGION IV									
Alabama									
Florida					114,005	1,575	Funds released	December	1976
Georgia									
Kentucky					142,870	-0-	Funds released	March 1977	
Mississippi									
North Carolina									
South Carolina									
Tennessee	4,399	Awarded in FY 1975	(FY 74 & FY 75) 87,999	50,6[illegible]3	12[illegible],3[illegible] *	51,332		179,215	102,215
REGION V									
Illinois			116,055	54,055	321,091 *	95,000		373,891	149,055
Indiana									
Michigan									
Minnesota					230,600	-0-	Conditional	award. Funds	not released.
Ohio			53,400	8,629	164,966 *	136,620		173,386	145,249
Wisconsin									
REGION VI									
Arkansas									
Louisiana			36,100	8,[illegible]	109,569 *	72,000		118,430	80,861
New Mexico					123,096	-0-	Conditional	award. Funds	not released.
Oklahoma									
Texas			41,000	5,968	126,542 *	84,500		132,510	90,468
					291,690	-0-	Conditional	award. Funds	not released.
REGION VII									
Iowa									
Kansas									
Missouri					82,806	41,400		82,806	41,400
Nebraska			58,100	58,100	117,041	-0-		173,141	58,100
REGION VIII									
Colorado									
Montana			41,107	41,107	-0-	-0-		41,107	41,107
North Dakota									
South Dakota			25,734	11,095	67,781 *	40,551		78,870	51,646
Utah					53,900	44,900		53,900	44,900
Wyoming			31,754	3,700	95,935 *	49,300		99,101	53,000
REGION IX									
American Samoa									
Arizona									
California									
Guam					439,498	-0-	Funds released	April 1977	
Hawaii	2,514	Awarded in FY 1975	FY 74 & 75 29,714	5,644	91,709 *	25,000		87,353	30,644
Nevada									
Trust Territory									
REGION X									
Alaska							TOTALS:	3,125,067	1,327,613
Idaho									
Oregon									
Washington					103,902	-0-	Conditional	award. Funds	not released.

*Includes FY 1976 grant awards and carry-over balance from prior year.

415

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CHILD ABUSE AND NEGLECT

Legislation and Issues

Legislation

On January 31, 1974, the Child Abuse Prevention and Treatment Act (P.L. 93-247) was enacted to provide Federal financial assistance for the identification, prevention and treatment of child abuse and neglect. The Act provided for the establishment of a National Center of Child Abuse and Neglect to collect and disseminate information on the subject as well as the incidence of child abuse and neglect. In addition it mandated the creation of an Advisory Board on Child Abuse and Neglect to assist the Secretary in coordinating Federal programs relating to child abuse and neglect and in the development of Federal standards for programs dealing in this area. Funding is available for project grants and research contracts designed to assist in the identification, prevention and treatment of child abuse and neglect. These are available for: technical assistance to public and nonprofit private agencies and organizations; demonstration programs and projects to develop multi-disciplinary training programs, establish and maintain centers to provide support services, provide technical and other assistance to professionals and support other innovative programs designed to identify and treat child abuse and neglect. Grants are also available to States which meet the requirements under Sec. 4(b)(2) of the Act. Requirements for eligibility under the State grant program include implementation of a State program which provides for reporting of known or suspected instances of child abuse and neglect; investigation of such reports by properly constituted authorities; provision of protective and treatment services to endangered children; effective administrative procedures and personnel to deal with child abuse and neglect; immunity provisions for persons reporting suspected instances of abuse or neglect in good faith; preservation of confidentiality of records with criminal sanctions for those illegally disseminating such records; cooperation between agencies dealing with child abuse and neglect cases; appointment of a guardian ad litem to represent an abused or neglected child in a judicial proceeding; and public dissemination of information on the problems, incidence and other related information assisting in the identification, prevention and treatment of child abuse and neglect. The States are also required to give special preference in providing funds to parental self-help organizations dealing with child abuse and neglect.

This program is administered through the Office of the Secretary, Department of Health, Education and Welfare under the direction of the Office of Child Development and the Director of the National Center for Child Abuse and Neglect, which is located in the Children's Bureau. Total funding authorized under the Act for the period 1974 through 1977 was $85 million and reauthorization will be necessary to continue funding beyond that time.

	Appropriations levels (in 000's)	(Authorizations (in 000's)
FY 1974	$ 4,500	$15,000
FY 1975	15,000	20,000
FY 1976	18,928	25,000
FY 1977	18,928	25,000
FY 1978	18,928 (Administration Budget Request)	

Summary of Activities under P.L. 93-247

In FY 1975 16 States had met the requirements of P.L. 93-247 Section 4(b)(2) and were eligible to receive Federal funds. Grants for programs relating to child abuse and neglect prevention in these States amounted to an estimated $902,251 for that year (See listing of States and amount each received under this Act). In FY 1976 the number of States eligible for grants under the act had grown to 29 and it is estimated that 37 States will be eligible for funds in FY 1977. HEW budget justifications for FY 1978 include eligibility for 43 States as an objective for that fiscal year. It should be noted that as the number of States meeting eligibility criteria for funding under this program grows, the amount of funding for each State program may diminish unless additional funds are authorized and appropriated, or unless the percentage of funds appropriated for State grants is increased. The reason for this is that the current law requires that no less than 5% or more than 20% of the funds appropriated be used for State grants. For FY 77 and 78 HEW has budgeted the full 20% of the appropriation allowed, for a grant total of

$3.785 million for each year to an estimated 37 States in FY 77 and 43 States in FY 78. By regulation, grant money budgeted for States and not used is returned to the National Center. It is not clear what will happen if more States than anticipated become eligible for grants. The amount of funding available to States is based on criteria established by the Secretary to achieve an equitable distribution of funds among the States and localities. No formula for allocation is specified in the law although the law requires that to the extent possible, each State should receive some assistance.

Child Abuse Prevention and Treatment Act - State Grant Program

State Grants FY 1974 - FY 1978 (est.)

FY 1974	$ 19,335	(3 States)
FY 1975	902,251	(16 States)
FY 1976 (includes transition quarter funds)	3,821,604	(29 States)
FY 1977	3,786,000	(37 States - est.)
FY 1978 (est.)	$3,786,000	(43 States - est.)

CRS-5

State Grant Awards

State	FY 1974	FY 1975	FY 1976	Transition Quarter
Hawaii	2,514	27,200	30,963	26,676
New York	12,422	161,700	231,806	146,375
Tennessee	4,399	53,600	70,581	50,635
Arkansas		36,800	45,659	35,971
Maine		28,600	33,180	27,955
Missouri		58,100	77,462	39,579
Oklahoma		41,100	52,192	39,318
Utah		31,200	37,224	30,677
Virginia		59,700	30,572	56,411
Illinois		112,800	158,443	102,648
Minnesota		53,400	70,309	49,877
New Hampshire		26,600	30,148	26,108
North Dakota		25,500	28,243	24,901
Vermont		23,900	25,988	23,528
Connecticut		44,700	56,934	41,875
Massachusetts		65,800	88,775	60,981
Rhode Island			31,042	26,487
Puerto Rico			65,643	51,819
New Jersey			[illegible]	72,416
Alabama			[illegible]	47,818
Georgia			84,265	58,613
Michigan			139,316	91,284
Texas			176,716	114,982
Louisiana			71,940	51,156
Kansas			46,826	35,980
South Dakota			28,748	25,232
California			269,283	170,215
Washington			62,339	45,663
Delaware			27,309*	

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*Applied too late for transition quarter.

Research and Demonstration

1975 reports on federally funded Child Abuse and Neglect projects and programs showed 63 various research and project grants awarded through the National Center for Child Abuse and Neglect (this does not include State grants). 17 of these provided funding for demonstration centers which were involved in management of child abuse and neglect cases and which included investigation, assessment, treatment, referral, public education, 24 hour hot-lines, supportive services and coordination with other agencies. Other research grants included funding for research, training development, technical assistance, evaluations, curricula development, innovative demonstration projects and information contracts directed at preventing, detecting, and treating child abuse and neglect. The National Center has continued to support these kinds of efforts.

The following table represents an estimate of how federal funds for child abuse and neglect prevention under P.L. 93-247 are budgeted for FY 77 (from the Budget Justifications for FY 1977).

12 Demonstration centers	$ 3,035,000
16 Resource projects	4,370,000
6 Research projects	925,000
Information clearinghouse	425,000
State grants	3,786,000
Dissemination of training materials	1,000,000
National survey of incidence	1,300,000
8 Demonstration projects	1,425,000
Technical assistance	1,600,000
Evaluation	950,000
Dissemination of information	112,000
Total ...	$18,928,000

Incidence of Child Abuse and Neglect

The most recent national data available on child abuse and neglect are for 1974, and were compiled by the National Clearinghouse on Child Neglect and Abuse of the American Humane Association. It should be noted that the actual incidence of child abuse and neglect is difficult to ascertain because of the reliance on reporting. The attached "Highlights of the 1974 National Data" provides information on reported cases only. Some experts assert that "as many as 10,000 children are severely battered each year, at least 50,000 to 70,000 are sexually abused, 100,000 are emotionally neglected and another 100,000 are physically, morally and educationally neglected." (Fontana, V.J., Somewhere a child is crying. 1973)

Issues

Despite the fact that this law has been in existence for more than three years, not all of the States have been able to meet the requirements for funding under the Act. States have cited several factors which have made it difficult to conform to the requirements of the Act. Among them is the time-consuming process of making the considerable changes required both administratively and legislatively to conform their current operations and State laws to those required under P.L. 93-247. Some States have objected to the requirement for a court-appointed guardian ad litem for children involved in abuse and neglect cases because of the costly, as well as time-consuming demand this puts on their judicial systems. Other States are having difficulty with the definition of child abuse because it includes "mental injury" which they find hard to define. HEW has indicated that all of the States are working toward meeting the requirements of the Act, but the limitation of funds for State grants (to between 5 and 20% of the total appropriated) may limit the actual fiscal inducements to meet the requirements.

This legislation, passed in 1974, called for "a complete and full study" of the national incidence of child abuse and neglect, as well as other determinations based on this information. Despite this legislative mandate and the fact that grants have been provided for purposes related to gathering this information, we still do not know what the actual incidence of child abuse and neglect is in the United States.

Issues relating to privacy and confidentiality of records have been raised with regard to the establishment of central registries in the States to: receive reports of suspected abuse and neglect; provide for monitoring and surveillance of responsiveness to reports; establish a tracking system of abused or neglected children, and their families; and provide a statistical profile of the incidence and social characteristics of these children and their families. Several States have set up central registries and the National Center on Child Abuse and Neglect recommends development. Some experts believe that the tracking part of the Central Registry is more potentially damaging than useful, in that currently all States have reporting laws (previously, this was not the case) and because previous assumptions that such families are highly mobile are proving to be less true and even if such families do move it is likely to be across State lines, in which case the effectiveness of a State tracking system is voided. There are also problems involved in a computerized system which is supposed to report all suspicions of abuse and neglect regardless of validity. Despite the fact that invalid reports are to be expunged from the system there is always the danger that they will not be; just as there is the danger that unauthorized persons will gain access to the information in the system. Examples have been cited of cases where an authorized person has asked the system for information on a specific case and received other confidential information not in any way related to that requested.

Other concerns include debates about the philosophy of expending large amounts of funds for research, training, evaluative and other efforts not directly dealing with prevention and treatment for abused and neglected children and their families.

Since the passage of the Act, other issues related to violence in the family have emerged. Some are concerned that this Act focuses too heavily on children and should address itself to all victims of violence in the family, including spouses. Recently reports have been made about the use of children in pornography. While the current legislation includes sexual abuse under the definition of child abuse, this particular aspect of violence against children has not been given much attention in research and related projects.

Jean Yavis Jones
Education and Public Welfare Division
February 17, 1977

NATIONAL CLEARINGHOUSE ON CHILD NEGLECT AND ABUSE
Children's Division, American Humane Association

HIGHLIGHTS OF 1974 NATIONAL DATA

These highlights are drawn from data gathered by the Clearinghouse to assess the national experience with the problem of child neglect and abuse during the calendar year 1974.

The reliability and accuracy of the data on which these highlights are based is subject to doubt because, for much of the information, the Clearinghouse had no opportunity to evaluate the primary sources or to participate in the analysis of the raw data.

Data was gathered from two principal sources. In-depth, more detailed and much more reliable data came from states actively participating in the Clearinghouse study. Twenty states, Guam, Puerto Rico and the Virgin Islands were such sources. This data was more or less uniform in content and detail.

Other data was supplied by twenty-nine states. This last information came in cumulative, less specific, less detailed form. This data lacked uniformity in structure and form, varied in content and lacked specificity.

Despite these caveats with regard to reliability, this report contains the best available data on national experience, and provides the only documentation on incidence and characteristics.

I. Reporting: Neglect and Abuse

Total number of reports of neglect and abuse	229,360	
Number of cases investigated	147,085	(64.1%)
Status undetermined	82,365	(35.9%)
Of investigated cases of neglect and abuse (147,085):		
Found to be valid	88,103	(59.9%)
Found not valid	58,982	(40.1%)

Thus the validation rate for neglect and abuse cases was found to be a ratio of 60-40.

II. Neglect versus Abuse

Number of neglect cases reported	71,466
Number of abuse cases reported	35,642

Ratio of neglect to abuse reporting was found to be 2 neglect to 1 abuse case.

Number of neglect/abuse cases (i.e. undifferentiated neglect and abuse)	122,252
TOTAL	229,360

Comment:

The 2-1 ratio of neglect over abuse reporting is biased to show a lower than true ratio because:

(1) Twelve states reported only abuse cases and made no count of neglect reports;

(2) No state reported neglect cases only;

(3) All reporting laws made reporting of abuse mandatory -- not all make neglect reporting mandatory;

(4) New York State statistics show a ratio of 5-1 for neglect versus abuse;

(5) Michigan shows a ratio of 6-1.

III. Sources of Reports

Neglect and abuse reports were made to the mandated authorities by many agencies and individuals in the communities. Data on this aspect of the study was grouped as follows:

Sources	Percentage of all Reports
Agency Sources Public and private social agencies, schools, and school personnel, law enforcement, courts, hotlines	43.13%
Individuals Neighbors, friends, relatives, siblings, self-referrals	39.65%
Medical Sources Hospitals, physicians, nurses, coroners, medical examiners	9.06%
Others, Not Specified	8.16%

IV. Who Were Alleged Abusers-Neglecters?

Findings identified natural parents as the persons principally responsible for neglect and abuse with a scattering of other caretakers:

Relationship		Percentage of Total
Natural Parents		84.3%
Mothers	52.0%	
Fathers	23.3%	
Unknown	9.0%	
	84.3%	
Step-parents		5.22%
Step-fathers	4.4%	
Step-mothers	.82%	
Adoptive Parents		.3%
Fathers	.17%	
Mothers	.13%	
Paramours		1.1%
Male	.8%	
Female	.3%	
Other Relatives		2.2%
Siblings	.3%	
Others	1.9%	
Baby Sitters		.6%

Other categories with miniscule percentages included foster parents, institutional staff, and neighbors. The percentages are rounded out by "unknowns."

V. Types of Abuse Reported*

These statistics relate to types of abuse identified in validated cases of abuse or neglect and abuse.

		Percentages of Total
Physical Injuries-Minor (contusions, abrasions, unspecified, no visible injuries)	31,440	77.9
Sexual Abuse	4,932	12.2
Physical Injuries-Major (bone fractures, subdural hematomas, internal injuries, brain damage, skull fractures)	1,474	3.7
Burns, Scalding	1,107	2.8
Fatalities	631	1.6
Congenital and Environmental Drug Addiction	602	1.5
Poisoning	123	.3
TOTAL	40,309	

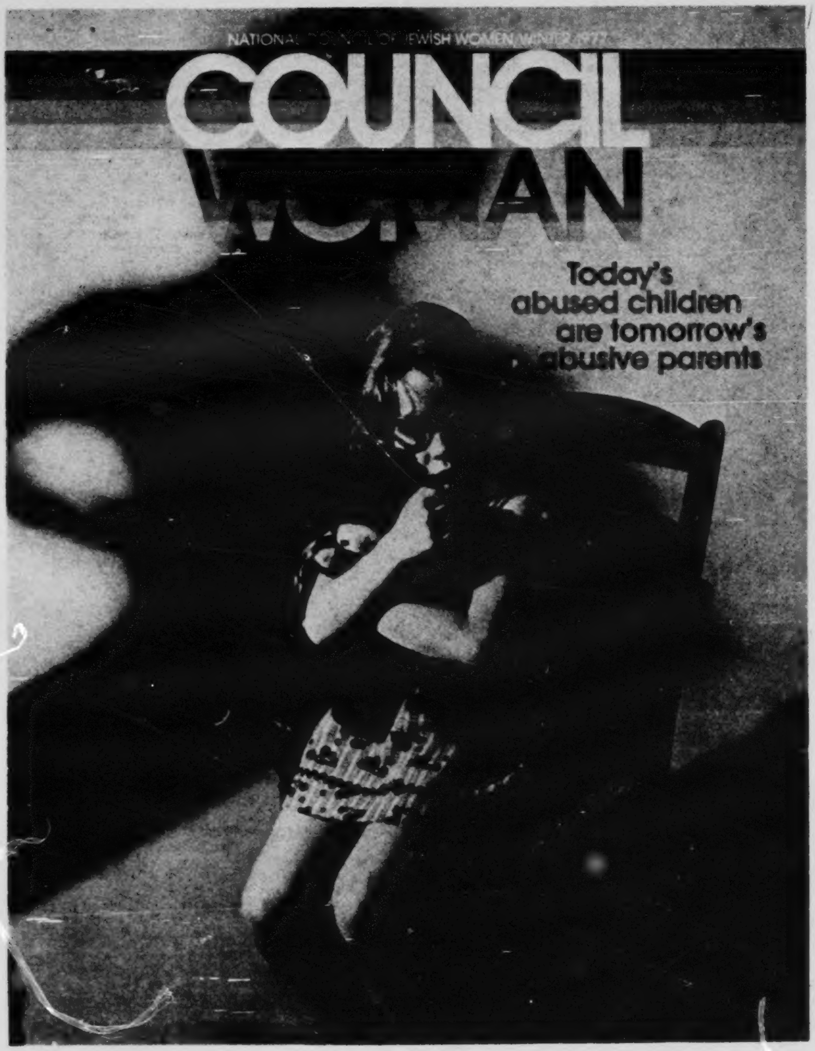
* More than one category may have been reported for each child.

VI. Types of Neglect Reported*

These statistics relate to types of neglect identified in validated cases of neglect or neglect and abuse.

		Percentages of Total
Physical Neglect (unspecified, gross household neglect, lack of supervision, abandonment, exposure to elements, inadequate shelter, clothing, hygiene, etc.)	66,472	78.7
Medical Neglect (lack of medical diagnosis & treatment, malnutrition, etc.)	7,586	8.9
Emotional Neglect (psychological impairment, failure to thrive)	5,514	6.5
Educational Neglect	3,088	3.7
Moral Neglect	1,824	2.2
Total	84,484	
Unknown and "Other"	21,267	

* More than one category may have been reported for each child.



NATIONAL COUNCIL OF JEWISH WOMEN WINTER 1977

COUNCIL WOMAN

Today's
abused children
are tomorrow's
abusive parents

THE PRESIDENT'S LETTER

Recently I watched a shocking three-hour TV documentary, "Violence in America," that included an especially shattering section on child abuse. It featured Dr. Vincent J. Fontana, a pioneer campaigner against this terrible disease of our society. Months before, we at Council had decided to devote this issue of *Council Woman* to the subject of child abuse, a major concern of our organization, and had asked Dr. Fontana to write on the subject. His article points up, as did the TV documentary, child abuse as an aspect of the violence in our society, harming not only abused children and their abusive parents, but everyone.

Child abuse is not a new concern of Council. It is an aspect of our deep concern for children, which caused us to emerge from the 1970 White House Conference on Children determined to study and improve our country's juvenile justice system. From that time until the Symposium on the Status Offender, which we sponsored last May in Washington, NCJW's energies have been devoted to correcting abuses rampant in the juvenile justice system. Now we realize we must also seek to correct abuses wrought by parents in the home.

Way back in the first years of NCJW, Council women realized the importance of improving the lives of abused children. Quoted in ***Where There's a Woman***, a history of NCJW, is a report by Sophie Axman of Kansas City that gives a glimpse of what Council's help had been worth to one cruelly tormented child she had met in her work: "Among the score that came to our little school for street children was Hotchky, a boy of six years. Upon one hand was an angry wound, inflicted by a red-hot poker in the hands of his mother."

For several days, said Mrs. Axman, a mute and withdrawn Hotchky attended the school. Then, "after a while his lips began to move as the children sang. It was a pantomime of song; there was no sound. Those silent, moving lips were the first sign of life. Then his hands began to move with the rhythm of the song, and then his feet, and then his poor little body swayed convulsively and with a strange and startled cry his voice rang out and he sang.... but there was a light in his eye, and an ecstasy in his face."

Esther R Landa
Esther R. Landa

Editor's Note

Why are we devoting an entire issue of *Council Woman* to the subject of child abuse? In her President's Letter, Esther R. Landa has outlined some of the major reasons: the shocking prevalence of this disease in our society; Council's historic concern for children; our commitment to correcting abuses in the juvenile justice system; and our recognition that many cases of delinquency derive from a home environment of abuse and neglect.

The articles in this issue present several facets of the problem: child abuse and neglect within the context of a violent society; how the pressures of our society can push some parents into abusive behavior; the uses and abuses of central registers of child abuse; how some of our Sections are participating in remedial programs.

As one Council woman wrote in her Section bulletin after attending a conference on child abuse, "The problem is enormous... and frightening."

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Cover Photo by John Gregory

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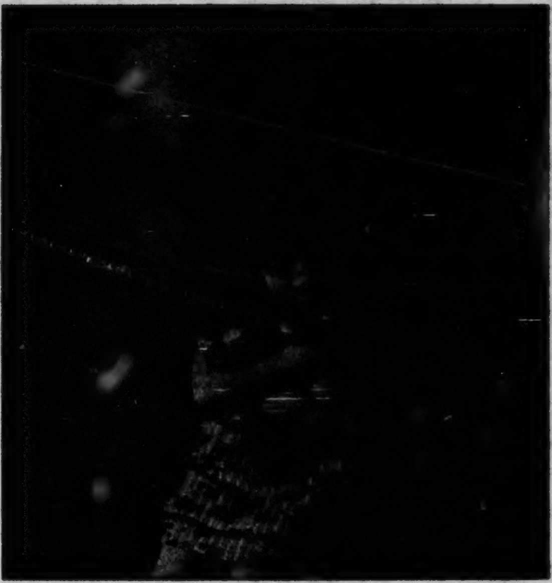


CHILD ABUSE— SYMPTOM OF A VIOLENT SOCIETY

To heal the disease of child abuse, we must find ways to heal the major ills of our society to which it is inextricably linked.

By Vincent J. Fontana, M.D.

Dr. Vincent J. Fontana, Medical Director and Pediatrician-in-Chief at the New York Foundling Hospital Center for Parent and Child Development, has been a pioneer in the campaign against child abuse. He is also Professor of Clinical Pediatrics, New York University College of Medicine, and Chairman of the Mayor's Task Force on Child Abuse and Neglect of the City of New York.

Child maltreatment—the physical, verbal, and sexual abuse of children—is one of the most important medical-social problems confronting our society today.

It has been estimated that at least 2,000 children are killed each year in this country by their parents or parent surrogates. In one year, in New York City alone, an average of two children every week die of maltreatment. Thousands of children throughout the United States are being permanently injured both physically and mentally each year. These figures are certainly cause for deep concern, especially since they probably reflect merely the visible tip of the iceberg.

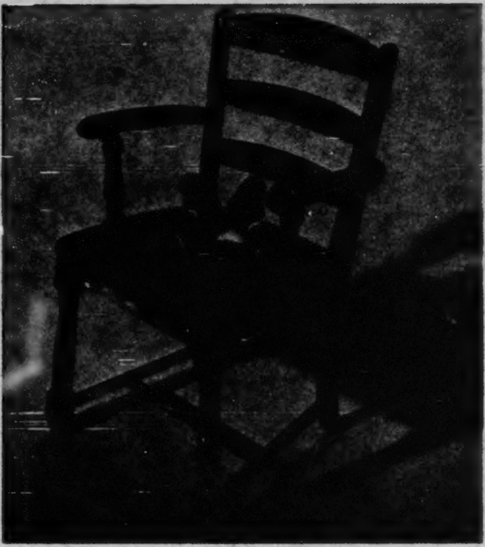
Child abuse is a symptom of the violence running rampant in our society today. If this disease is allowed to spread at its present pace, it will threaten the future of

Continued on page 4

PROTECTION FOR ANIMALS, NOT CHILDREN

The first recorded case of child abuse in the United States, reported in 1870 in New York City, was that of Mary Ellen, a child who was being severely beaten and malnourished by her parents. Some church workers became interested in obtaining a home for her but could not get local authorities to take legal action against the parents.

Since the right of parents to chastise their own child was sacred, no agency could by law obtain protection for the child. The church workers appealed to the Society for the Prevention of Cruelty to Animals (S.P.C.A.), which was able to have Mary Ellen removed from her home on the grounds that she was a member of the animal kingdom and that therefore her case came, by law, under the jurisdiction against animal cruelty. Essentially, the case of Mary Ellen led to the founding of the Society for the Prevention of Cruelty to Children, founded in New York in 1871. Other cities followed in creating organizations to protect children from harm.



CHILD ABUSE

Continued from page 3

our society and the entire fabric of our civilization. Child abuse is one form of violence that results in social disorganization and disintegration.

Dr. Karl Menninger has stated that "every criminal was an unloved and maltreated child." Persons who engage in violence tend to have been victims of violence. This generation's battered children, if they survive, will be the next generation's battering parents. As they approach adolescence, these children begin to show evidence of psychological and emotional disturbances leading to juvenile delinquency.

A recent report on the explosive rise of crime and violence appears to indicate an increase of offenders in the juvenile age group. These youngsters are undoubtedly coming from the large number of multi-troubled families wherein there is physical and emotional abuse of children. The rate of juvenile delinquency appears to be rising faster than the rate of the juvenile population. It is estimated that by the end of 1976, one out of every 9 youngsters will have appeared in the juvenile court before the age of 18.

In the course of many years as a pediatrician and as an activist in the field of child maltreatment, I have come to know countless parents who have battered, neglect[illegible]d abused their children. I have observed that parents vary considerably in their attitudes towards their children and their ability to love them. There are ambivalent latent feelings concerning children in all adults—admixtures of love and hate. Unfortunately, an appreciable number of parents cannot or do not adequately care for their children.

A growing child reacts according to what he learns through parental reinforcement of developmental behavior. Children attempt to cope with the threatening aspects of parents' behavior by doing actively what they experienced and continue to experience passively. Particularly during the first three or four years, called the imprinting years, the child learns a manner of behavior patterned on that of parent or parents. A child who is exposed to repeated episodes of violence—physical abuse, verbal abuse, neglect, or rejec-

tion—grows up angry.

Prolonged maternal deprivation can have a serious and lifelong impact on a child's future growth and personality development. Indifference can be devastating to a child, whether it stems from drug addiction or the ambition of a professional who has no time to bother with the baby.

Positive steps can be taken to help children who might otherwise become tragic statistics: hospital child abuse teams; parents anonymous groups; parental stress hotlines; homemakers; parent aides; community child abuse prevention and treatment centers; child advocate community groups; family health clinics; and expansion, funding, and realistic staffing with trained social workers of the Child Protective Units responsible for investigating reports of child abuse and neglect.

In the past decade severe maltreatment has been managed by separating the child from the parent by means of placement in a foster home. Unfortunately, this arrangement does not solve the problem of child abuse, since it offers no assistance or help to the abusing parents. Recent studies have sought to ascertain the causes and effects of violence as a force, within the family unit, that gives rise to child abuse. Findings of such studies have moved us toward creating change in the parents rather than confining ourselves to the limited role of changing the child's environment to a more safe and healthy one.

Child abuse preventive and treatment programs have already demonstrated that many parents can be helped to cope with their children and the stresses and strains of everyday living. A rational program to prevent child abuse and neglect must achieve two major goals if intervention is to be successful. Efforts must be made to offer professional and paraprofessional services that will enable parents to function more appropriately, or to provide a permanent substitute mother through foster home placement.

In order to recognize and meet the specific needs of these neglectful and abusing parents, one must study their personality structure, their social contacts and dealings with people, the degree of intrafamilial communication, their interreactions with their children in a child-rearing environment, their values and "hang-ups." Innovative programs must be undertaken in an attempt to break into the repetitive cycle of child maltreatment, involving successive generations of disorganized multi-problem families.

It is my belief, a belief in which virtually all my colleagues concur, that a large proportion of abusive and neglectful parents do not willfully harm their children. *Willfully* is the operative word. They know they are neglecting. They know a cry of pain when they hear one. Many would like to stop themselves if only they knew how, but they don't. They are inadequate, frightened people, incapable of parenting, and they don't like what they are.

Just as it is nearly impossible for them to change themselves without help, so it is extremely difficult for these emotionally frozen and isolated people to seek help. Therefore, we must begin on a purely personal, humane, reaching-out level. *Anyone* can try.

The violence in our society can only continue to increase so long as we think of child battering and neglect as something rather unfortunate and sometimes horrendous for the child in question, which has nothing to do with the rest of us. It is an ugly symptom of our times, but it is more than that. It is inextricably linked with unbearable stress, impossible living conditions, material or spiritual poverty, distorted values, disrespect for human life, drug addiction, alcoholism, assaults, armed robberies, murders, and other ills in the midst of which we live—and for which we must find massive healing.

It is born of this illness and violence and it will breed more of the same. If we cannot feel for the children who are even now being scarred and savaged, at least let us feel for ourselves and the kind of future we are shaping for ourselves and our own children. ●

WHY DO PARENTS HARM THEIR CHILDREN?

By Douglas J. Besharov and Susan H. Besharov

We need to understand how the pressures of our society can lead some parents to harm their children, before we can develop the services needed to break the cycle of abuse and neglect.

Thinking about child abuse and child neglect is painful for us all—so painful that we find it difficult to accept how many children are in fact maltreated. Our sense of human decency is shocked and offended when we learn of brutal attacks on defenseless children.

Yet child abuse and child neglect afflict all communities, regardless of race, religion or economic status. Recent studies indicate that there are as many as one million abused and neglected children in this country—as many as 200,000 are physically attacked each year, 106,000 sexually attacked, and the remainder neglected.

Douglas J. Besharov is director of the National Center on Child Abuse and Neglect, Children's Bureau, Department of Health, Education, and Welfare. Susan H. Besharov is a psychiatric social worker who has worked in the psychiatric department of a general hospital, in schools, and in private practice.

Now that the magnitude of child maltreatment is finally coming to light, there is a danger that the earlier denial of its existence will turn to outrage and over-reaction, as we recoil from the horrors of individual cases. But taking a punitive or retributive approach to parents is no solution. For unless we remove all endangered children from their parents, the only way to protect vulnerable children is by helping parents become capable of caring for them adequately.

Understanding the forces that can lead parents to harm their children is the first step in developing the compassion we need to help both parent and child. Child abuse must be understood as a function of uncontrolled or uncontrollable personal, familial, and social stress. Despite popular misconceptions, most abusing parents are not sadists, criminals, or mentally retarded persons. Abusing parents are capable of loving the children they harm, and they often experience great guilt and remorse about their abusive behavior. But when they experience moments of anger and frustration, they can take it out on their children. Sometimes they confuse discipline with the expression of their own inner fury.

The personal, or intrapsychic, dynamics of abusive and neglectful parents do not confine themselves to one psychiatric classification or personality type. Nevertheless, most of these parents share certain common characteristics that can unleash the violence and aggression which is deep within us all.

Research studies have found that many abusive and neglectful parents suffered unhappy childhoods themselves and that their own parents

were ungiving, critical, and unpredictable. Many were abused as children. That they in turn mistreat their own children should not be surprising. During times of stress, we sometimes see ourselves repeating the worst traits of our parents in dealing with our own children. Abusive parents do this to a much greater extent because they lack the personality strengths derived from the many positive experiences with their parents that most of us enjoyed in early childhood. There is thus a generational pattern or cycle of inadequate parenting that can lead to abuse or neglect.

Some abusive parents immaturely look to their children for the loving care they craved but were denied in their own childhoods. Unable to perceive the needs and limitations of their young children, they see crying, bed-wetting, and the whole range of normal baby behaviors as personal rejections. For example, agency case records often report the scalding of babies by parents who cannot accept the fact that their baby is not toilet trained. Even when the baby is far too young to control his or her bladder, its behavior is seen as an act of rejection and defiance that requires punishment to reassert parental authority and to make the child "learn." The feelings of weakness and helplessness already felt by these parents are reinforced, and they react with indignation, anger, and sometimes violence.

Many abusive parents also have a general distrust of others that leaves them sadly isolated and lonely. Many seem to expect rejection from others and act in a way that brings it on. As a result, they may have few friends to give them the support needed during the many stresses of parenthood.

Familial stress can be an additional contributing factor leading to abuse or neglect. The emotional burden placed on the nuclear family—husband, wife and children—is a hallmark of our modern, highly mobile society. Transient couples—without the companionship and extra hands of extended family, old friends, familiar neighbors and community resources—lack supports in raising their children. The inability to share with others the frustrations and questions as well as the joys of parenthood can make child rearing an unrelenting burden for some parents. Difficulties in finding trustworthy babysitters to provide temporary relief from the chores of parenting and to allow for rest and recreation ("R & R" in military terminology), only exacerbate the situation.

The women's movement and shifting attitudes about roles of mothers and fathers within the family provide an additional stress for some parents. While the authors strongly support the expanded life choices for women, we have observed from both professional and personal experience that the fundamental changes of the past decade can be a source of strain. Many women who would have assumed a generation ago that they would remain at home and dedicate themselves to the work of child care and homemaking now see this as a hard decision. The ambivalence felt by some who choose to stay at home can have a subtle effect on the ability to cope with the everyday crises of child care. And for those women who choose to work (43 percent of all

Continued on page 8

WHY DO PARENTS HARM THEIR CHILDREN?

Continued from page 7

married women were in the labor force by 1974), the inability to find adequate substitute care—day care, nursery school, after-school programs, or babysitting—is a source of added pressure.

The strains on the nuclear family are generally even greater for single-parent households. At present, 10 percent of white American households and 30 percent of black American households are single-parent families. This past year, more children were born to unmarried women than to married women in Washington, D.C. Most single-parent households provide suitable and nurturing environments for children and most single parents are tremendously resourceful in meeting the needs of their children, but the demands on them are great. On the other hand, although marriages differ, couples rely on each other to share and reduce the burdens of parenthood. After a difficult day, it is a great help to be able to say to one's spouse: "I've had it tonight. Can you put the kids to bed?" Single-parent households, as well as American families generally, need the kinds of supports that will enable parents to perform at an optimal level.

Another stress on families, often overlooked in efforts to understand abuse and neglect, is the unusually difficult child. A constantly crying, colicky infant who will not be consoled and who keeps his parents awake much of the night; an older hyperactive child; and children of all ages who suffer emotional difficulties or developmental disabilities—such children are trying for all parents and can push a vulnerable parent beyond the threshold of self-control.

In addition to such personal and familial pressures, social stresses, including many of today's major social and economic problems, can contribute to child abuse and neglect. Poverty, unemployment, and inadequate housing are but a few of the stresses on family life that can lead potentially abusive parents to strike out against their children. It is important to remember that most poor people do not abuse or neglect their children; indeed, many do a remarkable job in raising their families. But the stresses of poverty compound the tribulations of parenthood and can lead some parents to strike out against their children.

This brief outline of personal, familial and social stresses that can lead to child abuse and neglect is not meant to oversimplify the causes of child maltreatment. While many abusing parents share common traits as individuals and as parents, they also can have wide differences. Some may be struggling to cope with all aspects of their lives while others may function well in jobs, intellectual pursuits, community activities or housekeeping.

We need to understand the forces that can lead parents to harm their children before we can develop the services necessary to break the cycle of abuse and neglect. Thus, the two major goals of the National Center on Child Abuse and Neglect are: (1) increasing our knowledge about child abuse and neglect; and (2) applying that knowledge to improve and expand prevention and treatment efforts. The National Center was established by the Federal Child Abuse Prevention and Treatment Act of 1974, to implement the Congressional mandate to improve State and local child abuse and neglect services. The National Center, located in Washington, D.C., is an organizational part of the Children's Bureau of the U.S. Department of Health, Education, and Welfare. It seeks to focus and coordinate Federal efforts—including 150 specific projects—relating to child abuse and neglect. All projects aim at keeping families together and preventing the unnecessary placement of children.

For example, 28 demonstration treatment centers have been established to develop and test service techniques which, if they prove successful, can be replicated elsewhere. These projects provide total case management, where there is community-wide coordination of services. Most of the projects are using interdisciplinary teams of professionals to guide and coordinate their efforts. Depending on the project, they are performing child protective investigations; child and family assessments; and direct treatment, including group therapy, art therapy, and play therapy. Many are operating twenty-four hour hot lines (sometimes called "help lines") for parent counseling.

A grant has been made to Parents Anonymous, to expand its coverage across the country. Progress has been substantial—as of now, there are over 500 chapters of Parents Anonymous in the United States.

These new Federal programs are designed to establish the foundation for a broadly responsive and honestly realistic approach to the diverse needs of children in danger and families in trouble. But there are still major inadequacies, breakdowns, and gaps in the child protective process. Reports of child abuse and neglect are increasing faster than agencies can handle them (over 20 percent a year nationwide) but identification and reporting remain haphazard and incomplete. Child protective investigations are often poorly performed, and suitable treatment programs exist more in grant applications than in actual practice. Most importantly, prevention has proven to be an easily touted but little understood and unevenly pursued goal. Existing child protective procedures treat child abuse and neglect only after the fact, not on a primary, preventative level. Even the demonstration projects described earlier are really only dealing with secondary prevention by working with families at risk. Real progress in prevention will come only if we can incorporate into our daily lives the individual, family, and community supports necessary to meet the needs of parents and children.

We are witnessing the beginning—but only the beginning—of what must be a sustained national effort to understand the origins of child abuse and neglect and to help alleviate them. ●

KEEPING RECORDS
ON SUSPECTED CHILD ABUSES

The Central Register of child abuse is a vital tool, but one that can be misused.

By Alan N. Sussman

Few laws were as favorably received and quickly enacted by the 50 State Legislatures as were child abuse and neglect reporting laws in the late 1960's. Reporting laws generally require certain professionals—usually doctors, dentists, nurses, social workers, and school teachers—to report any suspicions of child abuse or neglect observed in their professional capacity. Reporting laws encourage private individuals to report their suspicions as well. Reports are usually made to welfare departments or the police, who in turn are charged with investigating the situation and, if necessary, taking appropriate remedial action. Reporting laws therefore facilitate the all-important purpose of bringing maltreated children out of the home and into the light of day so that they may receive the care and treatment they need. Reporting laws also focus attention on adults suspected of abuse or neglect so that they too may receive treatment or, if appropriate, punishment. In some cases, a report may ultimately result in short or long-term removal of a child from his parents.

Recently most states have added another component to their reporting laws—central registers which receive, store, and disseminate information about maltreated children and adults suspected of child abuse and neglect. In most states, the central register is located in the state capital, usually in the office of the Department of Social Welfare. Moreover, a number of large municipalities maintain central registers of their own, and a national register, located in Denver, Colorado, currently functions with the cooperation of over one-half the states of the union.

Alan N. Sussman, a New York attorney, was co-author with Stephan Cohen of Reporting Child Abuse and Neglect: Guidelines for Legislation, *published in 1975. His book* The Rights of Young People *has just been published in paperback.*

Reports of suspected child abuse and neglect reach central registers either directly, by reporters themselves—be they physicians or next-door neighbors—or through local social welfare agencies or police departments which initially receive reports and then forward them to the statewide central register. To encourage reporting by private individuals, many states and cities maintain toll-free, twenty-four-hour telephone service linked to the register, with the telephone number publicized on radio and television public service announcements.

In a society littered with computers, data banks, and centralized registers operated by police departments, credit companies, intelligence agencies, insurance companies, welfare departments, courts and other public agencies and private corporations—often with little regard for the privacy of individuals—it is necessary to ask whether child abuse registers are necessary and, if so, whether their purpose serves a legitimate social goal.

The most often-stated purpose served by central registers is that it provides social workers, police officers, or physicians with access to previously filed reports concerning cases under current examination. Such access, it is suggested, provides officials with a record of maltreatment or a pattern of injury that might otherwise escape notice, especially when adults may attempt to

The New York City Police Department receives reports of suspected child abuse at its main switchboard, pictured here. Photo by Bettye Lane

Continued on page 10

KEEPING RECORDS

Continued from page 9

avoid detection by repeatedly bringing their maltreated children to different doctors or hospitals or even by moving to other locations. Central registers may also permit social welfare agencies to manage their cases more efficiently and effectively by providing a record of treatment services offered to maltreated children and their families.

The *actual* purpose served by central registers, however, is not clear, simply because their function differs among the states that operate them. Their use—and possible abuse—is dependent upon the following factors: the nature of the information stored in registers; the scope of information divulged; the persons to whom information is disclosed; and the means, if any, available for the destruction of false, inaccurate or useless information.

Most states require reports stored in central registers to contain certain basic facts: the age and identity of the child suspected of being maltreated; the extent of his injury; the names and addresses of his parents or others responsible for his care; and the name and relation of the person making the report. Many states require much more. Some store information regarding the religion of the child, the economic status of the family, and the educational level attained by the parents. The national register requires fifty-five items of information, including family income, ethnicity, and marital status. It is difficult to understand the usefulness of collecting information other than minimal vital statistics, especially when considered in the light of evidence suggesting that few doctors or other professionals actually "consult" the register before making reports. When immense collections of data are stored and not fully utilized in the manner intended, the potential for improper use is increased.

The central issue concerning the use of child abuse registers is the amount of information divulged, and the persons to whom access is granted. Surprisingly, only a few states have laws which limit access to specified agencies or professionals. A number of states merely leave the problem of disclosure to be determined by the agency in charge of the register. Other state regulations simply require that information be "confidential" without defining the term. Uncontrolled discretion in releasing information is therefore considerable. As a result, in many states the ironic situation is created whereby those for whom disclosure was originally intended make little use of the register while other, unintended individuals, are granted relatively free access.

The possibility for misuse of information is increased when there are no provisions for the expungement of extraneous, false, or unnecessary data from the register. Once a report of suspected abuse or neglect is made, therefore, it may remain in the register forever. Many states make no distinction in the registers between reports of *suspected* neglect or abuse, and maltreatment which is actually *determined* pursuant to a social investigation or a judicial hearing. This permits false or even malicious reports to remain on file for uncertain purposes, for an indeterminate length of time, and possibly subject to wide dissemination.

It is quite easy for an angry neighbor or a jealous ex-spouse, for example, to report a case of child abuse or neglect for purposes of pure harassment. A visit by a police officer or social worker may turn up no evidence, but since a report has been made—no matter how outrageous—the person stands "convicted" by allegations stored in a computer.

In virtually no other area of law enforcement would such a situation be tolerated. If someone reported his suspicions to the police that his neighbor received stolen goods or that he sold narcotics and the police investigation uncovered no evidence of wrongdoing, the reported persons' names would not be on a statewide file of suspected thieves or dope dealers.

The situation is compounded when one considers that many state laws require reports of suspected *neglect* as well as abuse. Neglect laws are notoriously vague and defined in extremely broad language. Many state laws merely define child neglect in sweeping terms of "improper parental care" or "risk" of mental or physical harm. The possibility that economic, cultural, and social differences may be determining factors in notions of child neglect are, of course, considerable. The result is that thousands of reports are stored in registers which may, in the final analysis, indicate nothing other than the fact that the reporter's definition of child rearing differs from that of the reported.

Regardless of the severity of the problem of child maltreatment, it must be acknowledged that few labels are as emotionally charged as "child abuser," and the existence or dissemination of records containing inaccurate information could easily invade an individual's privacy, damage his reputation, and harm his livelihood. Children, too, may be damaged by the proliferation of child abuse records which are false or no longer meaningful. The label "abused," "neglected," or "psychologically injured" may follow a child for life, resulting in unwanted "special" treatment or undue state watchfulness, even when the definition is no longer appropriate.

A cautious approach to the utilization of central registers is not easily recommended, since no one wants either to permit defenseless children to exist in a dangerous environment or to hamper the efforts of those who are in a position of rendering efficient aid. But there is some question about whether the existence and utilization of child abuse and neglect registers actually serve the purpose of protecting children from harm. Moreover, the real problem of child abuse should not blur our vision and permit the undesirable result of justice meted by computer, social condemnation based on suspicion, or stigmatization of parents and children founded on inaccurate, incomplete or useless information. ●

Symposium on Behavioral Pediatrics

Child Abuse

Principles and Implications of Current Pediatric Practice

Eli H. Newberger, M.D.,[*]
and James N. Hyde, Jr., M.S.[**]

This paper summarizes data and experience with child abuse pertinent to child health practice. Because of the complex origin of child abuse, and because of institutional and social changes that will have to accompany excellent practice if child abuse is to be treated and prevented, issues of program and policy development are also addressed.

WHAT IS CHILD ABUSE?

The classic paper of Kempe and colleagues defined "the battered child syndrome" as "a term used by us to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent."[26] For the medical profession especially, which previously had not recognized a phenomenon centuries old, the impact of the paper was considerable.[41] The concept of child abuse as inflicted injury in the Kempe paper was admittedly narrow and was associated with constricted definitions of child abuse in the state child abuse reporting statutes which proliferated after the paper's publication.

Fontana proposed a more broadly defined "maltreatment syndrome," where the child "often presents itself without obvious signs of being battered but with the multiple minor evidences of emotional and, at times, nutritional deprivation, neglect and abuse. The battered child is only the last phase of the spectrum of the maltreatment syndrome."[9]

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Presented in part at the Conference on Research on Child Abuse, National Institute of Child Health and Human Development, Bethesda, June 1974. Supported in part by a grant from the Office of Child Development, Department of Health, Education and Welfare (Project OCD-62-141).

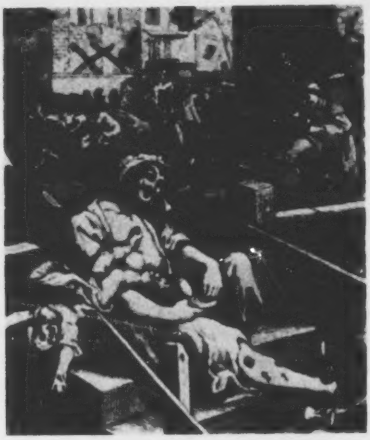

Figure 1. *Gin Lane*, by William Hogarth (1751), visually summarized the impact of alcoholism. In this detail are portrayed three metaphors of different aspects of a broadly conceived notion of child abuse: a mother's death and her child's abandonment, a child impaled on a stake and, prominent in the foreground, a baby tumbling from its drunken mother's arms to the sidewalk.[22]

Underlying both narrow and broad definitions of child abuse are implicit concepts of parental fault, which are vividly underlined in Chapter 1 of the second edition of Fontana's book *The Maltreated Child:* "Today . . . the important battle continues between the child murderer and the child saver."[9]

Such strong and angry responses to child abuse are not rare in the professional literature and in journalistic treatments of the subject. They derive in part from the intense feelings which cases of child abuse evoke in everyone and in part from our limited understanding of a complicated problem with multiple causes and many manifestations in child, adult personality, family, environment and culture.

The knowledge base about child abuse remains conceptually and methodologically limited, as the following statement in a working paper for the Joint Commission on the Mental Health of Children pungently points out: "We can state without equivocation that in view of the ubiquity of the problems here under view, and their contribution to a myriad of other social ills, the paucity of studies of substance and rigor is shocking. . . Endless fritterings of academic nonsense have gained funding under the dubious claim of constituting basic research, as if theoretical advances had never arisen from applied fields. Most such studies are of children easily brought under study, which usually implies considerable interest and intactness in their parents' personalities.'"[39]

Our understanding of the problem of child abuse is advanced by several recent descriptive reports which demonstrate that childhood accidents and child abuse are temporally associated,[11, 19, 23] that the parents of abused children are rarely neurotic or psychotic,[31] and that the developmental sequelae of child abuse and neglect are serious.[7, 30] Child abuse has also been observed to be associated with poverty, low birth weight, parental alcohol and drug abuse, crime, social isolation, marital stress, and unemployment.[14, 16, 27–29, 43, 44] There are also data which suggest that the coordinated interdisciplinary management of child abuse can reduce the toll of reinjury while children stay in their own homes.[4, 35]

A helpful integrating concept in the diagnosis and treatment of child abuse is the family's capacity to protect its child, either from the consequences of their own angry feelings toward him, or from the hazards of his nurturing environment. Whether or not an injury is intentionally inflicted is of interest and possibly of importance, but understanding its origin and identifying what can be done to strengthen the child's environment might better be the goals of diagnosis of child abuse.[34]

This is not to say that a parent's anger, expressed actively or passively toward a child, is not primary in many child abuse cases. Steele and others have drawn attention to abusing parents' excessive and premature expectations of their children.[12, 45] Often, the angry feelings of which the child's injury is a symptomatic expression appear to derive from the violent circumstances or deprivation of the parent's own upbringing, and they may reflect a deep disappointment that the child has not been able adequately to fulfill the parents' own nurturing needs.[24, 27] This last phenomenon has been called "role reversal" in the psychiatric literature.[32] It is indeed important in one's conversations with parents to ask about their feelings toward the child and to find out about what their own childhoods were like. A particularly sensitive chapter on how to approach parents of an abused child is found in "Helping the Battered Child and His Family."[40]

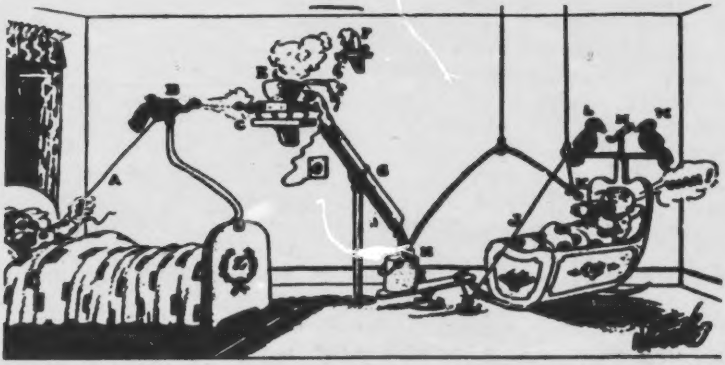

Figure 2. Rube Goldberg documented with characteristic flourish one parent's ability to protect his baby who awakened him in the middle of the night and made him angry: "Pull string (a), which discharges pistol (b) and bullet (c) hits switch on electric stove (d), warming pot of milk (e). Vapor from milk melts candle (f), which drips on handle of pot causing it to upset and spill milk down trough (g) and into can (h). Weight bears down on lever (i), pulling string (j) which brings nursing nipple (k) within baby's reach. In the meantime baby's yelling has awakened two pet crows (l and m) and they discover rubber worm (n) which they proceed to eat. Unable to masticate it, they pull it back and forth, causing cradle to rock and put baby to sleep. Put cotton in your ears so you will not be bothered if baby wakes again."[17]

In the development of a program to help a family better to protect its offspring, one needs to identify *strengths* in a family which can be built upon and *resources* which can operate effectively to integrate child and parent safely.

APPLICATION OF THE PROTECTIVE CONCEPT IN DIAGNOSIS AND INITIAL INTERVENTION

CASE 1. *Drugs, Injury and Denial.* A 10 month old boy was brought to the emergency room by his mother, a 19 year old unkempt woman who on arrival said that she had recently been taking illegal psychoactive drugs. Physical examination showed a stuporous child with a massive hematoma overlying the left orbit. On inspection the right eye was deviated leftward. The mother volunteered that she had been in the child's room where quite by chance a broom had fallen over a shoe. She inadvertently stepped on the shorter side of the broomstick, which, with the shoe as a fulcrum, catapulted the broom into the child's crib, hitting him on the head and causing his injury.

This blatantly fabricated explanation for the child's injury might be taken by a physician or nurse, angered by such a grievously injured baby, as an intentional falsification. One might be tempted to hammer away at the proffered story in an effort to make a definitive diagnosis of the "battered child syndrome." This might expiate some of one's own angry feelings, but it might actually harm the prospects for the establishment of professional relationships in order that both mother and child can receive the treatment they desperately need.

The mother's story should be accepted for the moment, and it should be construed by the professionals managing the case as representation of how profoundly threatening to the mother's sense of herself is the reality that she has been so unable to protect her baby. Her denial of this reality may be seen as a desperate attempt to hold herself together, and there may be a conscious effort to conceal the facts of the injury for fear of legal, punitive reprisal. Shorn of her defenses by an interrogatory diagnostic approach, she might resort to a more primitive ego defense, such as resistance to talking about the problem at all, blaming the hospital for the injury, or taking the child and running from the hospital.

One needs to give the child the necessary emergency treatment and protection and to attend to the parent's distress at the same time. It is appropriate to emphasize to the parent the need for the child's treatment and protection and to express one's ability and interest in helping the parent through the crisis. This is a difficult and vexing process for doctors and nurses, who can be overcome with anger toward abusing or neglectful parents. It is well to keep in mind the need to form a *helping relationship* which will lay the groundwork for future intervention to strengthen the protective ability of the mother and her tie to her child. This long-term management goal can be identified and kept in mind from the outset, notwithstanding the implicit or explicit efforts of the parent to obscure the true instrument, timing and circumstance of the child's injury, the parents' social status or personal attractiveness, and one's own angry feelings toward the parent.

CASE 2. *Poverty, Depression and Severe Neglect.* An 8 month old child came to the emergency room with her mother, who complained of her inability to gain weight. The mother was poorly dressed and obviously depressed. Physical examination showed a tiny, emaciated child who did not respond to play (Fig. 3). There were moderate hip and elbow contractures. Her weight and length were well below the third percentile. The mother was unmarried, and the patient was the fourth child of a fourth father. The mother was born and raised in North Carolina, where she left her oldest child on coming to Boston a year before to find work as a domestic. Both maternal grandparents were seriously ill in North Carolina. She had no child care for her two older preschool children. Mother and children were supported by Aid to Families with Dependent Children; the stipend was about $235 a month, of which $115 went for rent. The mother said her teeth ached constantly, but she had been unable to get to a dentist. She also complained of back pain, fever and listlessness, and a urinary tract infection was shortly discovered.

In this case, a young, depressed mother failed abjectly in her wish to settle her family in an alien metropolis. She could not get child care, dental care, decent employment or health care, including contraceptive services. Her child's neglect was not taken to be her fault, and a compassionately conducted family assessment permitted identifying a management program which enabled the child to thrive in her care. On discharge from the hospital, a homemaker came 3 days a week, a visiting nurse on alternate days. Weekly clinic visits were scheduled. Preschool services were found for her two older children. A social worker gave weekly counseling, which was associated with an increase in the mother's self esteem. Dental and medical treatment, along with the other elements in the management plan, were coordinated by the social worker.

At a 5 year follow-up the patient was physically and psychologically normal. Her family, including a new younger brother, were happy and healthy (Fig. 4).

Were one so inclined, one could, on the basis of medical criteria

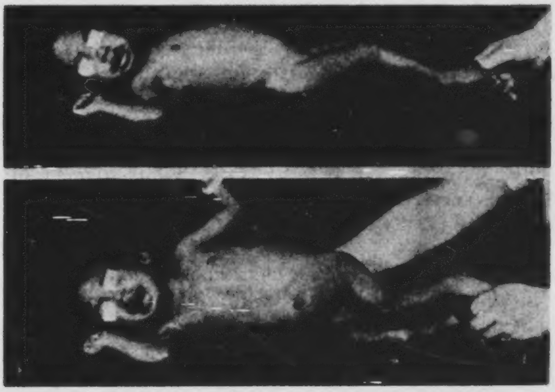

Figure 3. Case 2. Eight month old infant with failure to thrive whose mother was depressed, impoverished and ill.

Figure 4. Family of case 2, four years after intervention. The patient is at the left.

alone, argue successfully in virtually any district, juvenile or family court in the United States that this child was in need of care and protection and should be found by the court to be dependent on the State. Such a practice, which occurs regularly, could aptly be characterized as a form of "blaming the victim".[42] Here, both mother and child can be seen as victims of a social system which distributes jobs, goods, and child health and development resources unequally.[15]

Homemaker, child care, counseling and dental services are frequently expensive and difficult to obtain. The long-term effects on child and family of foster home placement, however, are known from recent studies both to be psychologically and financially costly.[8, 20] It is essential that medical personnel invest the necessary time and energy to assure that, when possible, families can stay together. To do so may involve, as it did in this case, time-consuming conferences with the welfare department, letters requesting homemaker and nursing services, purposeful and systematic efforts to engender a relationship of confidence and trust with a parent who has no previous successful experience with helping services, and convincing one's skeptical colleagues that staying with the family may be in the child's best long-term interest.

The arguments advanced in the recent book *Beyond the Best Interests of the Child* have been influential in framing discussions of the management of individual cases.[18] In this book, distinguished figures in psychiatry and law propose that the traditional criterion for decision-making in child welfare cases ("the best interest of the child") is insufficient. One would often do better, they note, to choose "the least detrimental alternative." Such a concept provides a yardstick to measure for the child in question the impact on his development of a decision affecting his family.

At the time the critical judgment was made to invest professional resources in this fragile family, one could not have been sure that the decision to send the child home with her mother was "the least detrimental alternative." Now it appears to have been. The capacity to *predict* the differential outcome of various interventions is limited. This is a provocative and helpful book for medical personnel concerned with child abuse and neglect. although a superficial reading of it may arm one's colleagues (if not oneself) with apparently simple and unitary formulas for complicated clinical problems with multiple causes. These demand flexibility and creativity in deploying intervention tools appropriate to each case.

CASE 3. *New Year's Eve and a "Battering Sibling."* A 2½ year old girl was brought by the police to the emergency room in a blanket after having been found unconscious on the grass outside a housing project on New Year's Eve

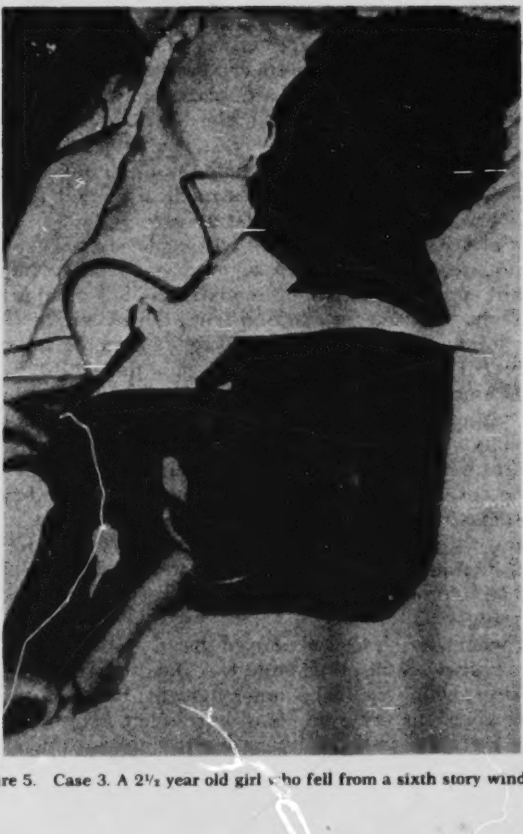

Figure 5. Case 3. A 2½ year old girl who fell from a sixth story window.

(Fig. 5). The outdoor temperature was in the low thirties. Physical examination showed a semicomatose child whose skin revealed a 3 cm. linear laceration of the left buttock and poor general physical hygiene, including tattoos of dirt on the plantar surfaces of both feet.

The child's mother arrived at the hospital within the hour and informed the physician that she had left the patient in the care of her 5 year old sibling. According to the sibling, the two had been running naked in the apartment, when the older child, angered at the patient, took a knife and chased her, managing to lacerate her buttock before she climbed upon the window ledge, and in her desperation to escape from her sister, opened the window and jumped from the sixth floor.

Further interview disclosed that the patient's mother became pregnant with the older sibling, whose behavior had previously been noted by a local health center to be distressed, when she was a resident at a training school for girls, to which she was sent by the juvenile court after *her* mother asked that she be declared a stubborn child. By virtue of her child's birth, she became an emancipated minor. She was liberated to live with her child in a housing project on an Aid to Families with Dependent Children stipend, estranged from her mother and family and alienated from the social "services" which had so clumsily intervened in her own young life.

One might look on this case as an example of the "battering child" syndrome[1] and simply attribute the child's abuse to a different "perpetrator" than the parent customarily identified as the cause of the child's injury. Similarly, a more penetrating and accurate formulation might address the obvious failure of the mother to protect her 2 year old from her predatory sister. Both "diagnoses" are correct, in the sense that they address proximal causes of the presenting lesions. Unfortunately, however, the roots of the problem extend deeper. One may look on this patient's injuries as symptoms of more complex familial and social problems, which challenge one's capacity as a medical worker to cure the individual case or to prevent future similar cases.

The origins of the 2 year old's injury are at least two generations back, from the distressed relationship between her mother and grandmother. The court action which led to the mother's placement in a training school – in reality a prison for children – may have been the only way that the grandmother was able to get help for her problems with her teenaged daughter. This is an example of how so often, as Bronfenbrenner aptly noted, American service institutions are divisive rather than integrative of families.[3] Additionally, one might observe that the services which society made available to this young mother when she was a child, the court and the delinquency "program," could neither anticipate her future nor provide adequate services when she became a mother. Other social institutions, the welfare "service" system, the Boston public housing "program," and the child health services which were equipped only to do minimal health promotion, conspired passively to let her not inconsiderable personal and psychological problems take their toll on her offspring.

It was only when her child was abused that a systematic and coordinated effort to provide counseling, child care, health care, homemaker and better housing began. Ironically, and tragically, it was necessary to invoke the authority of the same juvenile court which committed her as an adolescent to force her to accept these services. It was impossible to convince this mother that we meant to help her better to care for her children. Her experience with "helping" services had been unrewarding or punitive, and she had no basis for trust.

As medical practice is currently organized, it is often impossible to operate effectively on the causes of individual child abuse cases such as this one. To prevent future such cases will require attention to the distribution and quality of such social services as housing, health and counseling, the courts, schools, as well as opportunities to compete for the essential goods of society.

The disturbing question of whether our culture actually *needs* child abuse has been raised by Gil and by Gelles.[13,16] Simply summarized, the question is whether the sensational nature of the problem conveniently obscures its true social determinants (Gil uses the provocative metaphor "smokescreen" of public and professional interest), both because of society's need to obscure its neglect of so many of its young by depriving them of the resources necessary for them to grow in families whose basic needs for goods and services are met, and because of individual families' needs to make acceptable their own violent parenting practices.

The acceptance of violence in our culture is undoubtedly part of the complex causal underpinning of child abuse. A vivid visual reminder of the acceptability, and even the desirability, of violence in our culture is found in Figure 6, which portrays the culmination of a "fox kill" in rural Virginia. Here, a toddler is giving the *coup de grace* to a fox driven from its lair into a circle of waiting clubs.

These three cases give a general impression of the complexity of child abuse. Its diagnosis requires more than a comfortable reconciling of symptoms with parental explanation; its management includes tools not found in the medical clinician's own office; and its prevention shall involve addressing cultural traditions, social values and economic realities which exert a deleterious impact on a family's ability to protect its offspring.

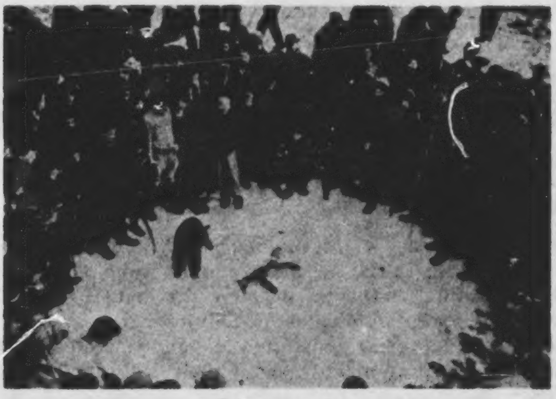

Figure 6. "Fox Kill," Life Magazine, 1942.

Figure 7. Case 4. Three week old infant with hand-shaped ecchymosis on left temple.

The next case raises another complex set of questions, including the mental illness of a parent and the problems associated with the reporting of middle-class families where child abuse has occurred.

CASE 4. *A Professional Person's Child.* A 3 week old boy was brought to the emergency room by his mother, who promptly informed the staff that the child had received his injury, a hand-shaped ecchymosis over the left temporoparietal area, at the hands of his father, a professional person who worked in another hospital in the Boston area (Fig. 7). The professional staff was reluctant to report the case, as mandated by law, to the Department of Public Welfare. The father was seen by a social worker and psychiatrist, who noted a severe personality disorder, with paranoid features and poor impulse control. He associated the birth of his first child with a sense of abandonment by his wife.

In the present case, the issue of primary adult psychopathology is raised. The findings in the psychiatric and psychological literature are somewhat in conflict on this point. One controlled study of the personalities of abusing parents indicates no definite pattern of neurosis, drawing attention to severely frustrated dependency needs and serious parental inabilities to empathize with their children.[31] Another larger study, where the cases were of significantly lower social class than the controls, indicated a high prevalence of parental personality disorders and neuroses.[44] Here, the psychiatric consultant's perceptions and recommendations were helpful in treating the problem.

It is well known that professional personnel are frequently reluctant to report child abuse cases from middle and upper-class homes. Surveys of the private practitioners who care for the children of more affluent families indicate that they are seeing many more cases than they report.[2, 36] And the 1965 poll of a representative sample of ordinary American citizens conducted by the National Opinion Research Center as part of Gil's national study of child abuse in the late 1960's led to a national incidence extrapolation for which the 95 per cent confidence interval was 2.5 to 4.03 million cases, at a time when fewer than 7000 cases were reported each year.[16] The data suggest that child abuse is more prevalent among middle and upper-class families than case reports indicate.

The same survey also posed the intriguing question, "Could you injure a child under a year of age in your care?" to which 6 of 10 respondents gave an affirmative reply.

A disproportionate number of families who are poor or nonwhite appear in case series of child abuse and in registers of child abuse case reports. To what extent do the circumstances of poverty contribute to this apparently greater frequency of the phenomenon among poor people? And to what extent does the preferential selection for reporting of impoverished families make it appear that poor people abuse their children more? Recent research findings suggest that certain environmental and social stresses are importantly associated with child abuse.[37] These may be experienced disproportionately—but not exclusively—among the poor.

Figure 8 displays child abuse case reports to the Boston area Welfare Department in 1971. The legend at the top which summarizes the numbers of cases reported by physicians in practice suggests in part why such a large number of the cases on the rolls were poor. The reports came predominantly from four inner-city hospitals with active

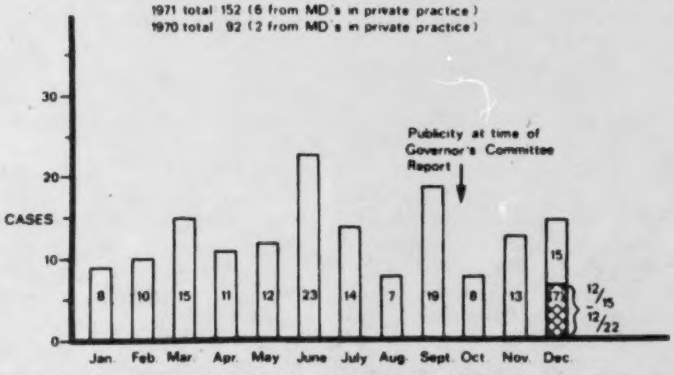

Figure 8. Case reports from physicians, Division of Child Guardianship, Boston metropolitan area, 1971.

emergency services, where poor families' children receive episodic primary care. Also of note in the figure is the high weekly prevalence of child abuse in the week before Christmas. This implies that child abuse, like such other human troubles as suicides, disturbances in prisons and mental hospitals, and violent crimes, gets worse at times of year when people long for missing family supports, and, in their desperation, may turn on their children when they make unacceptable nurturing demands.

HOW EXTENSIVE IS CHILD ABUSE?

There have been many efforts in the interval since Kempe's landmark paper to gather insight into the extent of the problem of child abuse in America. Gil's projected upper-bound estimate of between 2.5 and 4 million cases each year[16] contrasts sharply with the extrapolation to the national experience of the findings of a 1970 survey of physicians and hospitals in Massachusetts.[33] The incidence figure applied to the population of all 50 states resulted in an annual estimate of 200,000 cases. In 1972, approximately 22,000 cases of child abuse were officially reported, while Kempe in the same year estimated that there were about 60,000 incidents.[6, 21]

One cannot but be impressed that information from such respected and competent sources can be so widely divergent. There are several explanations:

1. No uniform definition exists for the events being counted. While some experts employ narrow definitions, such as the one implicit in the phrase "battered child syndrome," others include in their estimates children who are neglected or have suffered emotional abuse.
2. Estimates which derive from cases reported to state and local authorities reflect artifacts of bias toward the reporting of certain demographic groups in particular areas.
3. Incidence estimates derived from child abuse case reports lump together data from many different jurisdictions. These have diverse criteria for reportability.

Clinicians may wonder why they should be concerned with the problems of defining the extent of child abuse. The matter is of concern because of the current state of the service delivery system and the availability of services for families whose children have been or are at risk of being abused. The recent enactment of federal child abuse legislation, PL93-247, as well as the continuing evolution of state statutes across the country, has focused national attention on the problem. At present there are few if any states which have child protective service personnel and resources to deal adequately with the ever-increasing number of new cases reported, not to mention the much larger number of families who have already been identified as needing services.

Table 1 contrasts the relatively small number of case reports in 1968 with the much larger number in an incomplete 1972 survey.[6, 16]

Because the services provided in the public sector are an integral part of the child abuse management system in all states, it is well for

Table 1. *Comparison of 1968 Reporting Statistics with 1972 Experience*

	GIL, 1968[16]			SUSSMAN AND COHEN, 1972[9]				
							Confirmed	
STATE	Total	Abuse	Non-Abuse	Total Abuse and Neglect	Abuse	Neglect	Abuse	Neglect
Alabama	43	34	9	3826	87	3739	-	-[a]
Alaska	11	10	1	349	145	204	87	33
Arizona	2	2	0	-	-	-	-	-
Arkansas	20	17	3	4092	92	4000[b]	-	-
California	4016	1258	2758	39,564	5592	33,972	-	-
Colorado	78	67	11	373	373	-	-	-
Connecticut	78	73	5	-	-	-	-	-
Delaware	16	13	3	349	49	300	-	-
Florida	10	9	1	29,964	-	-	9711[c]	-
Georgia	62	55	7	320	320	NA[d]	-	NA[d]
Hawaii	42	35	7	1051	609	442	274	206
Idaho	2	2	0	-	-	-	-	-
Illinois	494	376	118	8011	1028	6983	-	-
Indiana	125	124	[illegible]	710	710	NA[d]	-	NA[d]
Iowa	186	132	54	-	-	-	-	-
Kansas	61	58	3	2331	888	1443	-	-
Kentucky	40	34	6	300	300	-	-	-
Louisana	14	13	1	-	-	-	-	-
Maine	5	4	1	-	-	-	-	-
Maryland	504	324	180	-	-	-	-	-
Massachusetts	156	114	42	3512	212	3300	201[b]	-
Michigan	721	539	182	16,204	1748	14,456	-	-
Minnesota	107	95	12	262	262	NA[d]	-	-
Mississippi	23	22	1	29	29	-	-	-
Missouri	72	54	18	935	935	NA[d]	-	NA[d]
Montana	11	8	3	-	-	-	-	-
Nebraska	16	16	0	-	-	-	-	-
Nevada	39	31	8	-	-	-	-	-
New Hampshire	23	20	3	-	-	-	-	-
New Jersey	50	37	13	3214	-	-	-	-
New Mexico	13	13	0	-	-	-	-	-
New York	989	574	415	3319	3319	-	-	-
North Carolina	155	102	53	1[illegible],064	1602	8462	-	-
North Dakota	2	2	0	9	9	-	-	-
Ohio	146	128	18	1119	-	-	-	-
Oklahoma	12	12	0	400	-	-	-	-
Oregon	30	30	0	347	-	-	-	-
Pennsylvania	555	385	170	1080	1080	-	532	-
Rhode Island	0	0	0	2060	-	-	1502[c]	-
South Carolina	41	38	3	27	27	-	-	-
South Dakota	0	0	0	-	-	-	-	-
Tennessee	116	72	44	372	372	-	98	-
Texas	1282	1282	0	1027	-	-	338	-
Utah	27	17	10	-	-	-	-	-
Vermont	7	6	1	12	12	-	-	-
Virginia	48	35	13	92	92	-	-	-
Washington	122	81	41	5500	1200	4300	-	-
West Virginia	16	15	1	41	41	-	-	-
Wisconsin	296	213	83	632	632	NA[d]	-	NA[d]
Wyoming	4	4	0	178	59	119	-	-

[a] Not available
[b] Estimated
[c] Total Abuse and Neglect
[d] Not applicable

physicians and other professionals concerned with child abuse to be aware of disparities between need and service. Accurate data on the incidence of new cases and the prevalence of children already identified, and therefore still at risk, will be an important stimulus for the improvement of services to abused children and their families.

OVERVIEW OF CURRENT CHILD ABUSE REPORTING LEGISLATION

All 50 states have child abuse reporting laws which mandate certain professionals to report cases of child abuse or neglect. While the specific details of these statutes vary, the formats of the individual laws follow similar patterns.[5, 10, 38] Currently, 36 states incorporate *statement of purpose* clauses in their statutes.[46] The majority of these statements speak to: (a) the necessity of providing protection to the child; (b) the prevention of further abuse; (c) the provision of services to families; and (d) the non-punitive intent of the law: to help the family rather than to identify and punish the perpetrator of the act.

There is variability in the manner in which states have chosen to define abuse, and the trend nationally has been in the direction of *broadening the definition*. While some laws enumerate reportable conditions in technical language, others may define abuse as generally as "...exploiting a child to such an extent that the child's health, morals, or emotional well-being is endangered".[46] Wald's recent scholarly review speaks pointedly to the need for the development of realistic standards.[48]

As the trend in defining child abuse has expanded the criteria for reportable conditions, so too has the *list of mandated professionals required to report* been lengthened. All states require physicians to report; 34 states require reporting by nurses, 25 by social workers, 24 by teachers and 9 states by police officers.[10] Additionally, 16 states require reporting by "another person who has reasonable cause to suspect," and all states *permit* reporting by any citizen.[10]

Immunity from liability for reporting cases of suspected abuse is a universal feature of these statutes.

Most child abuse laws *abrogate privileged communication* between patient, client and physician, social worker or other mandated professional when such communications involve child abuse as defined by the individual statute.

Many child abuse reporting laws treat extensively the *procedure to be followed by the agency receiving a report*. Most often this involves: (a) investigation of the situation leading to the report within a specified period of time; (b) provision of services to the victim and his family; and (c) authorization empowering the mandated agency to remove a child from its home in a bona fide emergency, in six states without having to prove in court the degree of danger.[46]

Most states include provisions for the establishment of a *central register* as a repository for information of all reported cases of abuse and neglect.

The majority of states have provisions for some form of *penalty for failure to report*. The sanctions in these states range from a simple misdemeanor to one year in prison or a $100 fine. Kempe has recently noted that a person failing to report a case of child abuse may be liable for damages in a civil suit.[25] There are now at least two cases in which physicians and a hospital were sued for malpractice. In one, a substantial award was made.

IMPLICATIONS OF CHILD ABUSE REPORTING STATUTES FOR CLINICAL PRACTICE AND SOCIAL POLICY

An accepted tenet of child abuse management tells professionals to be compassionate and to convey to parents their interest in helping to maintain the integrity of the family unit. On the other hand, child abuse reporting laws force physicians and others to make judgments about families which they and the family may feel are onerous and heavily value-laden. Additionally, the perceived effect of reporting is to bring to bear a quasi-legal mechanism which, while in theory nonpunitive in orientation, may be the opposite in practice. In such states as Virginia and California, parents may be jailed as a result of the mandated case report.

One may thus be torn between one's legal responsibility to report and one's clinical judgment which may suggest that reporting itself may jeopardize the opportunity to develop a satisfactory treatment program for the family. Often this conflict is expressed in reticence to inform families that they are being reported, or reluctance and even frank refusal to report cases of abuse and neglect.

While there are no cut and dried rules which resolve this conflict definitively, two simple guidelines make it easier for the mandated professional to come to terms with legal responsibility and clinical judgment:

1. The family must be told that a report is being filed. Much of the apprehension which may surround the receipt of this information can be alleviated by explaining to the family what the reporting process is and is not; it does not necessarily mean that the child will be taken away or that a court hearing will be held. The reporting process can best be presented to the family as a referral of the family for services, and an explicit acknowledgment that they have a serious problem in protecting their child which others, including the reporting practitioner, can help to solve.
2. The mandated reporter can also explain to the family that the report represents an obligation on the part of the practitioner which he or she is bound by law to fulfill.

Often, rather than reacting in a hostile or angry way, families will greet the news with relief. The reporting process may produce help which they have been seeking for a long time, and they may be relieved to hear that the suspicions others have had about them and their parenting are finally out in the open where they can be dealt with in a straightforward manner.

While such an approach to child abuse case reporting may palliate the anxiety of reporter and family, it does not remove the real, inherent labeling and stigmatizing aspects of the reporting process as it exists in most of the states today. Unfortunately, this is a problem that cannot be alleviated simply by a revision of reporting itself; it is rather an aspect of our society's perception of child abuse and the abusing parent. So long as child abuse is viewed as a form of radically deviant behavior, and as a symptom of pathology and sickness in others, the stigmatizing process will continue. All concerned to prevent and treat child abuse have, therefore, a responsibility to demythologize the problem: to recognize that the potential to act in ways which we identify as deviant is in all of us. Until attitudes and policies change toward troubled families, where children may bear physical signs of their distress, we shall have to work within the prevailing legal framework and to assure to the extent possible that children and families are helped – not harmed – by it.

All state statutes abrogate privileged communication when it involves a case of known or suspected child abuse. In reporting to mandated state agencies, the reporter should identify the facts as they are known; hearsay and secondary source information can be labeled as such. At least 44 states have provisions in their statutes for central registers, which may become repositories for information both founded and unfounded, depending on the expungement provisions of the individual statutes. Who has access to this information is left up to the individual states, and it is well to remember that information that is submitted in such reports may be used at some later date to raise the issue of competency of a family or the risk to a child.

The principle on which most prevailing statutes are built is that services should be made available to families in which child abuse has been reported as a problem. The reality in most states is that the actual funds available for the implementation of these statutes nowhere nearly approximates the existing demand for services. This problem has been seriously exacerbated recently by expanding reporting criteria and lists of professionals mandated to report cases of abuse and neglect.

Even in the presence of an efficient system for identifying families where child abuse has occurred, budgetary constraints may make it impossible for adequate services to be provided except in the most critical of cases. This makes it incumbent on the individual reporting a case not simply to view the report as a referral for service which will go forth with or without the professional's continued involvement in its management, but rather to *assure* that help will be given and that the family will not fall between the cracks of the service structure.

The essential elements of child abuse and neglect emergency management are summarized in Table 2.

MODEL SYSTEMS

Translating these complex and sophisticated clinical practices into effective programs for large numbers of children and families is a challenge not to be taken lightly. In closing we should like to propose 14

Table 2. *Emergency Management of Child Abuse and Neglect*

Diagnosis

Is this child at risk? If his presenting complaint arouses suspicion, act on it forthrightly and compassionately. Protect the child and help his family.

Intervention

Is it safe to send the child home?

Admission to the hospital considered in suspected cases and often when the diagnosis of abuse or neglect is established.

Social worker called.

Assessment

General medical history and physical examination. "Who did it?" is not the issue. Avoid the third degree.

Initial interview and assessment of the family by a social worker; development of understanding of family's strengths and resources.

Nursing evaluation of child's development, parent-child relationship, and family's participation in community health structures.

Honest explanation of the legal responsibility to report the case to the welfare department by the physician.

Report to the public agency mandated by law to receive reports of cases of child abuse and neglect.

Photograph and skeletal survey if indicated.

Appropriate consultations, especially psychiatry, as indicated.

Communication among physician, social worker, and nurse to decide program of care.

Intervention Program

Initiation of rehabilitative efforts for both child and family.

Mobilization of hospital and community resources which may be available for the family, e.g. child care, foster placement, community family service and health agencies.

Follow-up

Primary medical care arranged.

Social service follow-up – community service or public agency, as indicated.

Nursing follow-up as indicated.

attributes of model systems for the prevention and control of child abuse and neglect. These general programmatic principles would apply at various levels of scale, from individual medical practice to hospital to community service agency to state.

1. Child abuse seen as a symptom of *family crisis*, with professional services oriented to making families stronger.

2. Recognition of the community context in which child abuse occurs: attention to the values of the community, its indigenous techniques of problem solving, its traditions of child rearing, its resources and its leadership, in both the development of programs to help families, and in the approach to preventing child abuse on a larger social scale.

3. Services should be able to respond creatively to individual families' problems with services suited to their needs, to include: (a) social work counseling, liaison with other services and structures; (b) medical and psychiatric consultation and, where necessary, treatment; (c) advocacy; (d) child development services, including education, child care and psychological intervention; (e) legal services; (f) temporary foster home care; and (g) round-the-clock emergency services, such as homemaker services, to prevent family break-up and continued child abuse or neglect.

4. Protection of information about people; consistent and rigorous identification of the rights of children and their parents; and advocacy at all levels of intervention action to assure that fundamental civil liberties are not violated.

5. Regular evaluation of the effectiveness of intervention on several levels: for the individual case, both to assure continued physical protection and the promotion of health and psychological growth; and for the program in general, to assure the adherence to the highest principles of human service.

6. It would identify who is responsible to whom for what; minimize to the extent possible uninformed, reflexive and precipitous action on the part of intervention personnel; maximize the career development possibilities for these personnel in the context of the program structure; integrate into the career development program a systematic method for recruiting and training professional personnel from minority groups; and allow for the acknowledgment and reward of successful work.

7. Services would be provided 24 hours a day.

8. There would be an adequate commitment of resources to assure that a successful program would be able to continue.

9. It would assure adequate legal representation for all parties in any court proceeding relating to child abuse; and active and high-level advocacy to assure judicial determinations consonant with the high standards of modern family law. Its goal would be to integrate families rather than to punish parents; to use the authority of the court, when necessary, to force family change; and, as a last resort when families utterly and completely fail, to allow children who are dependent on the state maximal opportunities for growth in homes they can identify as their own.

10. Administrative organization allowing both flexibility in staff development, supervision, and assignment and at the same time high-level access to the human services leadership, in order most effectively to promote collaboration, constructive and mutual program planning, and, ultimately, the evolution of a human service system which would identify the *family* as the unit of practice, rather than as, at present, to fragment health, social and psychological problems into discrete program units.

11. It would incorporate child advocacy (as defined in the report of the Joint Commission on the Mental Health of Children) and child development education.

12. Systematic attention to the development of public policies which strengthen family life, based on what is already known about family strength and stress.

13. Citizen supervision of professional policies and practices through community-based councils for children.

14. The program should be population based: all people should be eligible for service. Neither a small-scale pilot program nor a major undertaking focusing only on the protection of the children whose cases happen to be reported, it should identify the dimensions of the problem and all possible avenues of individual and larger-scale intervention, as well

as recruit and sustain the interest and participation of competent and varied providers of service. Emphatically, it should not be identified as a poor people's program, although it is certain that many children of the poor will be reported, partly but not exclusively because of the circumstances of poverty which may lead their families to fail. It should be a program to which private medical practitioners and voluntary family service agencies, as well as suburban school systems, would feel comfortable in reporting cases, because its services would be helpful and its orientation toward keeping families together and toward preventing child abuse.

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Working with High-Risk Families:

Family Advocacy and the Parent Education Program

by Jessica H. Daniel and James N. Hyde, Jr.

The Family Development Study, a descriptive case-control study of families whose children exhibit the effects of such pediatric social illnesses as child abuse, accidents, ingestions and failure to thrive, has been conducted over the past two years at Children's Hospital Medical Center, Boston, Massachusetts. Supported by a grant from the Office of Child Development, the study is attempting to determine the extent to which past and present stresses in a family's history and environment contribute to such social illnesses.

While our ongoing research focuses on stress within the family constellation, we were also concerned with learning more about the strengths which serve to ameliorate tensions in the family unit.

A long-range objective of the Family Development Study is to begin exploring certain non-traditional modes of intervention in working with families whose children have been identified as being at risk. In this context, two models of intervention—Family Advocacy and the Parent Education Program (PEP)—have been tentatively employed for working with high-risk families. We hope that, as we gain experience in using these forms of intervention, they will become part of a variety of treatment options open to professionals working with parents whose children exhibit signs of abuse and neglect as well as other symptoms of decreased family functioning.

A distinctive characteristic of the Family Advocacy and PEP programs as intervention processes is that, unlike many other methods, they deal primarily, if not exclusively, with the present. Past or historical stress is defined as stress which occured at any time during the life of the caretaker prior to the conception of the child. While we accept the fact that contemporary or present stress often involves an historical component, the family advocate or PEP leader must work within the present environment and under constraints already well established.

During the time that a family is seen by the advocates and PEP leader, many stresses are operating in the family. These may be related to the family itself, to the marriage or to the environment, or stress may be derived simply from health problems of family members. Similarly, there are often stresses associated with the unique characteristics of the child in question, some of which are susceptible to change (severe dental problems, for example), but some of which are a permanent part of the child's identity (prematurity or birth defects). Such permanent characteristics are often beyond the direct reach of the advocate or PEP leader, although they may refer families to a doctor, psychologist, psychiatrist or social worker who may help both the parent and child adapt to a constraint which cannot be removed. However, the components of stress which are ideally suited to intervention on the part of an advocate or PEP leader include those stemming from housing and legal problems, employment difficulties, isolation, and lack of education or access to health care.

While one of the principal goals of the Advocacy and PEP programs is to ameliorate some of the problems which confront families, both are also concerned with the process of intervention. Many of the families with whom we work have become frustrated by the entire constellation of problems with which they must deal and, as a result, they have experienced a loss of control over their lives. By working with parents around specific environmental and social problems, we hope that they will develop a renewed sense of personal efficacy and control and begin to see themselves not as passive victims but as active agents, better able to control their physical and psychological environment, as well as that of their children.

Parent Education Program

The Parent Education Program is aimed at helping parents acknowledge and use their strengths in order to better meet their personal needs and increase their awareness and ability to meet the needs of other family members. While the ultimate goal is to improve the quality of their interaction with others, the emphasis is often on a particular parent-child relationship.

Intervention through a parent education program may also be effective in preventing incidences of child abuse

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and neglect in high-risk families. For example, many abusing and neglectful parents have unrealistic expectations for their children, some because of a lack of knowledge of child development. These parents may interact inappropriately with their children, fail to stimulate or play with them, or demonstrate a very limited repertoire of activities. In these instances, information about child growth and development might prove to be helpful.

A disproportionately high percentage of parents who are reported as being abusive or neglectful are poor, often unemployed or underemployed. It is generally agreed that many have limited access to and, therefore, underutilize community services. Receiving specific information about available services, learning through role-playing and gaining support from other parents may provide the impetus for them to better articulate their needs for assistance. A parent education program can also offer information about job training and help with formulating career goals.

Since many abusing and neglectful parents have been found to have poor self-concepts or low self-esteem, recognizing parents' positive qualities and helping them to develop more positive feelings toward themselves are elements which can also be incorporated into a parent education program.

PEP has involved 20 mothers in a series of therapeutic teaching sessions held in the spring of the last two years. Although none of the mothers had ever been characterized as being abusive or neglectful, they were considered vulnerable—living in poverty and coping alone with the demands of raising small children.

The mothers themselves were black, generally young (under age 20) and single, with one or two children aged three months to three years. Parents and children were regularly attending a community agency whose goal was to increase the mothers' skills in parenting, homemaking, stimulation-instruction, health care and other areas. Mothers participated in the center program on a volunteer (walk-in) basis as well as on a referral (outreach and community agency) basis. They participated voluntarily in the PEP program.

The group leader met with approximately eight to 12 mothers in 2-hour sessions once a week for 12 to 14 weeks. Child care was provided at the center. During the initial meetings, the group leader directed the content of the sessions but she became more a resource than a leader as the sessions progressed and leaders emerged among the participants.

The content of the therapeutic teaching sessions can be divided into two sections: one for the parent and one for the child. The latter includes parent-child interaction.

PEP is aimed primarily at the family that is "parenting under stress."

We were interested in helping the mothers set goals apart from those of being a mother, and in helping them to acquire the knowledge and skills needed to reach their goals. We began with goals that were usually attainable—losing weight, for example, or enrolling in a technical school or in a program to obtain a high school equivalency diploma.

Some sessions focused on budgeting, planning time, and organizing activities to help improve the mothers' household management techniques. In discussions about childrearing, we emphasized the joys as well as the trials of children at various stages of development. Stimulating play activities, using materials found in the home, were taught. Our discussions emphasized how mothers could keep their children entertained while they were doing housework.

PEP differs from many other parent education programs since it is aimed primarily at the family that is "parenting under stress." It acknowledges that the behavior of a particular child may be a source of stress, and it also recognizes that numerous other psychological and environmental stresses—social and physical—are impinging on the family. It is assumed, in part, that if parents are helped to develop a positive sense of self through successful experiences in a stressful environment, they can learn to see positive behavior attributes in their peers and so begin to develop a capacity to reach out and offer constructive support to them. Once they move in this direction, parents are then able to begin relating to their children in a positive and supportive manner.

Recently, the PEP model has been introduced as part of a hospital-based program for parents now participating in Children's Hospital's Child Abuse Management Program.

Family Advocacy

The Advocacy component of the Family Development Study was initiated with two specific goals in mind:

- To provide services to families being followed in order to assure that they receive help with problems expressed in the course of extensive interviews held in the hospital to gather data for the study.
- To begin to develop a new mode of intervention for working with families in which a child's illness could be construed as symptomatic of a disturbance in family functioning.

We also hoped to sensitize hospital staff to the needs and problems which often accompany children from high-risk families.

When mothers were asked at the conclusion of the interview whether or not they would like assistance with specific problems, 23 percent of mothers involved in case studies and 23 percent of mothers in the control group—a total of 128 families—requested and used the services of the Family Development Study's two advocates. About 20 percent of those who requested the advocates' services had children who exhibited effects of possible abuse or neglect.

Drawn from the community, the advocates have no formal professional training but they are given extensive supervision and job training. After a request for assistance had been made, the advocate contacted the family by telephone or visited the home so that a more detailed description of the principal problem could be obtained. The most prevalent problems were environmental in nature and related to housing, while others were related to welfare, day care and employment. Once a request for assistance had been confirmed, the advocates sat down with the family and described in detail what steps would have to be taken to solve the particular problem.

Most of the problems for which families requested services did not have short-term, immediate solutions but required several weeks, or even months, before they could be resolved. During this interval the advocates kept in constant touch with the families both by telephone and through frequent home visits. As a result of these extensive contacts, it soon became apparent that the problems for which families initially requested assistance represented only their most immediate problems. In reality, many of the families required intensive help and work from several individuals.

It is important to emphasize that during this period of intensive contact with families—about five months on the average—the advocates presented themselves as members of a team working with the family. The physician providing for the child's primary care, the social worker (if there was one) and other community-based agencies that may have been working with the family were all involved by the advocates. Families were encouraged to use these resources appropriately so that dependency on the advocates could be reduced as soon as possible.

While we are still attempting to evaluate the outcome of the advocates' work, several concrete results give a rough index as to the promise and acceptance of the Advocacy program:

- Using a very crude index of "family functioning" based on the absence or reoccurrance of a child presenting medical problems (such as accidents or abuse), and on the child's overall health status since being identified by the study, review of the records of some of the original families followed by the advocates indicates that about 60 percent are "functioning" better than they were prior to intervention.
- The majority of families have been able to handle separation from the program very well and have gone on to use other agencies and organizations in the community more effectively than before.

- Those families who have renewed contact with the advocates usually request help with a specific problem, which indicates the families have an increased ability to articulate their need for assistance, as well as an ability to mobilize resources on their own.
- From an institutional point of view, one index of the success of the program has been that the hospital has participated in the expansion of the program and in securing additional advocates to work with families not primarily part of the Family Development Study.

The goal of Family Advocacy, then, is to help families, and their individual members, to develop and function at their best. While this goal does not differ significantly from that of many other intervention plans, there are some basic differences. For example, the advocate is seen as an integrator and facilitator who relies not on a single method or technique of intervention but who tailors his or her approach to the particular problem at hand. Thus, while a telephone call to a landlord may be effective in having a family's heat restored in one situation, it may become necessary in another situation to secure a lawyer and, subsequently, a court order on behalf of the family.

Each situation has to be approached with the knowledge that there is a vast range of methods and techniques available, any combination of which may suit the needs of a specific family while proving useless when applied to another.

Second, advocacy does not seek to replace other more traditional forms of intervention. It seeks instead to maximize a family's access to and use of services. This is a central concept of the program.

Finally, the role of "process" and outcome in the evaluation of the advocate's effectiveness is also of crucial importance. Advocacy is not solely concerned with such objective measures of outcome as getting a family a new apartment, securing legal assistance, or finding someone a job. While it is commonly believed that advocacy is primarily oriented toward securing goods and services for people, advocacy, ultimately, is aimed at providing families and individuals with the technical and psychological resources to solve their own problems. The steps that the advocate takes to secure a new apartment for a family, for example, really constitute a learning process for that family, a process which once learned may be applied to seeking solutions to other problems.

In the long run, what an individual learns about his ability to effect change in his own life may be of far greater significance than the change itself. Therefore, if the evaluation of an advocacy program is aimed merely at objective outcome measures (apartment or jobs), it fails to measure the real long-term impact of an advocate

(Continued on page 36)

High-Risk Families— *(Continued from page 25)*

on the life of a family and, ultimately, of the child.

Conclusions

Both PEP and Family Advocacy have been presented as two models of non-traditional methods of intervention that appear to hold some promise for working with high-risk families. Although the programs are structured in different ways, there are some important similarities between the two techniques both in content and goals.

Both strategies attempt to focus on the provision of specific services or information which can be used by families to deal with individual problems or crisis situations. While problem-solving is directed at a specific issue at hand, the process which is taught may be applied to solving other situations.

Family Advocacy and PEP are oriented toward acknowledging and building on family strengths. There is planned support of the individual by both the advocate and the group leader, and strategies are goal-oriented and designed to teach decision-making and persistence.

Both programs emphasize the development of some independence from the service provider and are aimed toward developing in the individual a renewed sense of efficacy and control over the psychological and environmental stresses in his or her life. Through this process, both seek to enhance parents' self-concept.

Finally, both programs are ultimately aimed at preventing episodes of abuse and neglect and enhancing the conditions for the child's physical and emotional development.

From our limited experience over the past two years, we believe that the Parent Education Program and Family Advocacy hold promise for expanding the treatment options open to professionals working with families whose children bear symptoms of disturbances in family functioning. While it is clear that neither of these two models alone provide the key to breaking the cycle of abuse in all circumstances, they certainly warrant further attention and exploration. ■

460

REDUCING THE LITERAL AND HUMAN COST OF CHILD ABUSE: IMPACT OF A NEW HOSPITAL MANAGEMENT SYSTEM

BY

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ABSTRACT. Social service personnel from one public and two voluntary agencies were integrated into a consultation group in an academic pediatric hospital, leading to a reduction in the actual cost of medical services and the risk of reinjury subsequent to the diagnosis of child abuse. In the 1969–1970 hospital year, 68 cases of child abuse were seen, of which 39 were hospitalized. The average hospital stay was 29 days; the average hospital cost $3,000. Total hospital costs for the 39 cases were $123,000, of which bed costs made up $95,000. There were at least three subsequent incidents of child abuse in these 39 cases, and there was one subsequent death; the reinjury rate was 10% for hospitalized cases.

In September 1970 the Trauma X Group, an interdisciplinary, interagency consultation unit based in the hospital, was formed. With formal consultation and continued surveillance after discharge by the Trauma X Group, the following data were obtained from the 1970–1971 hospital year. Of 86 cases, 60 were hospitalized. The average hospital stay was 17 days; the average hospital cost $2,500. Total hospital costs for the 60 cases was $150,000, of which bed costs made up $101,000. There was one incident of reinjury and no deaths subsequent to diagnosis in these 60 cases; the reinjury rate was 1.7%. The risk of reinjury calculated from a modified life table was reduced from 8% in the year previous to the formation of the group to 7% and 2%, respectively, in the subsequent year and six-month periods, supporting the dollar-cost impression of effectiveness. Foster placement, furthermore, was infrequent and does not explain the differential impact of the Trauma X Group in the intervals under study. *Pediatrics*, 51:840, 1973, CHILD ABUSE, BATTERED CHILD SYNDROME, QUALITY OF CARE, EVALUATION OF FAMILY INTERVENTION.

THE challenge posed by the initial recognition or suspicion of child abuse is traditionally met by the personnel of a hospital in an urban setting in a variety of ways, ranging from frank refusal to accept the diagnosis to a quick proferring of a variety of professional services.[1] Occasionally, but not always, a long-range therapeutic plan, with particular attention to continuing supportive relationships, is developed by physician, nurse, psychiatrist, and social worker as the diagnostic formulation and communication with the relevant community agencies proceeds.

Experience at our hospital and elsewhere indicates, however, that even the best-laid plans seem frequently to be frustrated by a combination of factors associated with those severe family crises where a child's life falls into jeopardy.[2] These include the personalities of his parents, for whom denial and projection often serve as principal means of ego defense[3]; his family's anxious confusion in confronting an array of clinical specialty services and social agencies working disconjugately to protect their child from themselves[4,5]; the exigencies of life in poverty, including mistrust of community

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TABLE I

SOCIAL DIAGNOSTIC DATA FOR PRESENTATION AT TRAUMA X MEETING

Date
Division/Clinic
Patient's First Name
DOB ____________________
Address ____________________

Social Worker: ____________________
REFERRAL: ____________________ DATE: ____________________
DESCRIPTION OF INJURY: ____________________
FAMILY CONSTELLATION:
  Names/B.D.–Parents:
  Ethnic Group:
  Employment–Source of Income:
  Names/B.D.–Siblings:

PREVIOUS AND CURRENT COMMUNITY CONTACTS:
  Worker:
  Agency:
  When:

INTERVIEW(S) WITH PARENTS: DATES: WHERE:
  Attitude toward injury/hospitalization:
  Perceptions/Expectations of child:
  Parents' view of own upbringings:
  Family Stresses:

POTENTIAL STRENGTHS:
  1. Family
  2. Supportive personal ties:
    a. Neighborhood
    b. Agency
    c. School
    d. Church, etc.

DIAGNOSTIC IMPRESSION:

TREATMENT PLAN:

GAPS IN MANAGEMENT:

IMPRESSIONS OF OUTCOME
  1. Without intervention
  2. With recommended plan

QUESTIONS FOR DISCUSSION:

TRAUMA MEETING NOTES:

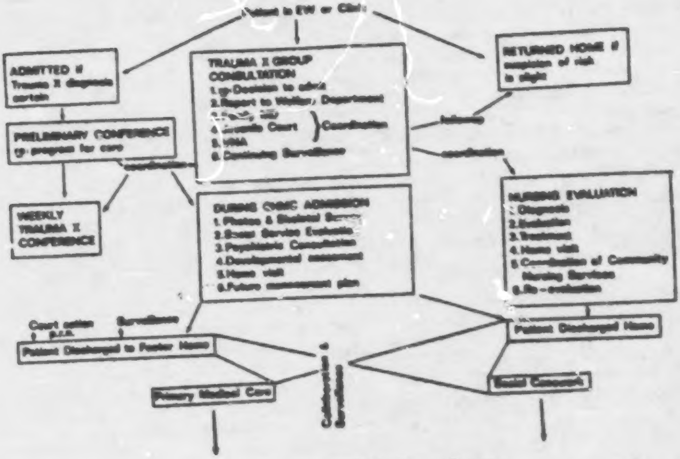
Patient to EW or Clinic
ADMITTED if Trauma X diagnosis certain
TRAUMA X GROUP CONSULTATION
1. Decision to admit
2. Report to Welfare Department
4. Juvenile Court
Coordination
6. Continuing Surveillance
RETURNED HOME if suspicion of risk is slight
PRELIMINARY CONFERENCE program for care
coordination
followup
WEEKLY TRAUMA X CONFERENCE
DURING CLINIC ADMISSION
1. Photos & Skeletal Survey
2. Social Service Evaluation
3. Psychiatric Consultation
4. Developmental assessment
5. Home visit
6. Future management plan
NURSING EVALUATION
1. Diagnosis
2. Evaluation
3. Treatment
4. Home visit
5. Coordination of Community Nursing Services
6. Re-evaluation
Court action
Surveillance
Patient Discharged to Foster Home
Patient Discharged Home
Primary Medical Care
Social Casework

Fig. 1. Management model for Trauma X cases.

institutions, racism, unemployment, and drugs[6]; the clinical team's frustration generated by missed appointments, confrontations with angry parents, and time-consuming contacts with outside agencies; and conflicts among the responsible personnel stemming from the emotions brought forth by prolonged contact with disturbed families.[7]

No one can adequately measure the human cost of child abuse. The present study is designed to demonstrate the effectiveness of a collaborative community effort to provide more nearly adequate preventive and therapeutic help to the victims of child abuse and their families. The evaluation of dollar costs and of a very crude measure of the behavioral effectiveness of intervention—the reinjury of a child—is intended both to promote awareness of the considerable literal and human expense of these cases, and to show how this toll can be reduced by an effort to coordinate human services of a kind which in the United States are generally isolated in State Departments of Welfare and fragmented among institutions whose programs attend to specific aspects of child health, mental health, and social welfare.

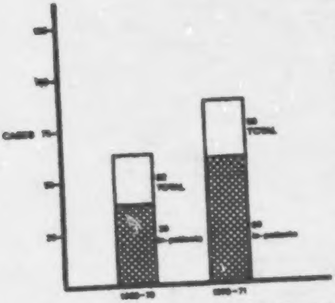

Fig. 2. Trauma X patients, Children's Hospital Medical Center, Boston, Massachusetts.

METHODS

In September 1970 an interdisciplinary, interagency consultation unit, the Trauma X Group, was formed at Children's Hospital in response to a crisis in the system for the protection of children living in Massachusetts.[9]

A shortage of personnel in the state agency designated by law to receive reports of child abuse cases and to provide protective services led to an appraisal of the prevailing method of hospital case management. Until that time, physicians had simply reported cases of suspected inflicted injury to the Department of Public Welfare, whose resources to deliver protective social services were severely limited. The number of injuries subsequent to initial diagnosis were apparently high, and our staff—as well as our colleagues in the Welfare Department—agreed that a more systematic program of case-finding, evaluation, intervention, and follow-up was necessary.

Accordingly, a group of interested individuals reviewed the problem; house management guidelines were written; and a concerted effort was made to recruit the interest and support of the chiefs of the clinical departments and the administration of the hospital. The functions of the Trauma X Group were defined as follows:

1. To become informed of each new case of inflicted injury or neglect.
2. To participate in the formulation of the plan for disposition and continuing care of the child.
3. Periodically to review the entire active hospital roster of Trauma X cases for purposes of evaluation and quality control.
4. To develop, in conjunction with the Department of Public Welfare, a unified proposal to the Juvenile Court in those cases where legal action was necessary. A designated member of the Trauma X Group would represent the hospital staff in court in such situations.
5. To educate the house staff, social service staff, and nursing staff in the pathogenesis of the problem and enlightened approaches to its control.
6. To serve as a focus at the Hospital for advancing the competence of the Boston community to deal effectively with child abuse and neglect. This function included the development of better channels of communication with other agencies and the discussion of health policy alternatives which affected the index population.
7. To carry on research into the determinants and concomitants of child abuse and neglect. This role integrated the responsibilities to monitor the clinical progress of the hospital population and to advance knowledge of the field in etiology and in the methodology of intervention.

A management model for the management of all Trauma X cases was proposed to the hospital staff at the time of the organization of the Trauma X Group (Fig. 1).

The three social agencies who regularly offer consultation on the management of

TABLE II

REINJURY AFTER DIAGNOSIS*

	1969–1970	*1970–1971*
Reinjuries after Trauma X diagnosis	3	1
Deaths subsequent to diagnosis	1	0
Rate of reinjury	4/39 = 10%	1/60 = 1.7%
	(data to 1/1/72)	

* Trauma X inpatients, Children's Hospital Medical Center, Boston, Massachusetts.

TABLE III

TRAUMA X CASES
CUMULATIVE LIFE TABLE DATA

	9/15/69 to 9/14/70	9/15/70 to 9/14/71	9/15/71 to 8/14/72
Person-months observed	507	646	180
Reinjuries in the interval	4	5	1
Risk of reinjury	9%	7%	9%

TABLE IV

Life Table: 9/15/69 to 9/14/70

Month After Entry X	Observed At X	Lost Anniversary at X	Observed X to (X+1)	First Reinjury X to (X+1)
0-	69	0	69	0
1-	69	3	67	3
2-	63	3	62	1
3-	61	1	60	1
4-	59	3	59	0
5-	58	0	58	0
6-	38	0	18	0
7-	18	5	16	0
8-	14	0	14	0
9-	14	5	9	0
10-	9	3	6	0
11-	6	6	3	0
12-	3			

	Probability of Reinjury X to (X+1)	Probability of Survival X to (X+1)	Cumulative Probability of Survival to X
0-	0	1.00	1.00
1-	.04	.96	1.00
2-	.02	.98	.96
3-	.02	.98	.94
4-	0	1.00	.92
5-	0	1.00	.92
6-	0	1.00	.92
7-	0	1.00	.92
8-	0	1.00	.92
9-	0	1.00	.92
10-	0	1.00	.92
11-	0	1.00	.92
12-	0	1.00	.92

Risk of reinjury in the interval = 8%.

TABLE V

Life Table: 9/15/70 to 9/14/71

Month After Entry X	Observed at X	Lost Anniversary at X	Observed X to (X+1)	First Reinjury X to (X+1)
0-	107	0	107	0
1-	107	6	101	3
2-	98	11	87	0
3-	87	0	79	0
4-	79	8	78	1
5-	78	10	68	0
6-	68	9	60	0
7-	60	7	61	0
8-	41	0	50	1
9-	35	16	17	0
10-	17	10	7	0
11-	7	6	1	0
12-	1			

	Probability of Reinjury X to (X+1)	Probability of Survival X to (X+1)	Cumulative Probability of Survival to X
0-	.00	1.00	1.00
1-	.03	.97	1.00
2-	.00	1.00	.97
3-	.00	1.00	.97
4-	.01	.99	.97
5-	.00	1.00	.96
6-	.00	1.00	.96
7-	.00	1.00	.96
8-	.02	.97	.96
9-	.00	1.00	.93
10-	.00	1.00	.93
11-	.00	1.00	.93
12-			

Risk of reinjury in the interval = 7%.

Children's Hospital cases of child abuse, through participation in the Trauma X Group, are the Department of Public Welfare (Inflicted Injury Unit, Division of Family and Children's Services), and two voluntary agencies, Children's Protective Services and Parents' and Children's Services. Regular representation from the Children's Hospital staff at Trauma X meetings comes from the administration and from the departments of medicine, psychiatry, radiology, social service, and nursing. Legal consultation is acquired through several sources: from the hospital's own legal counsel, from a lawyer associated with the Laboratory of Community Psychiatry at the Harvard Medical School, and from a consultant retained for certain protective actions in the Juvenile Court.

A full-time Case Data Coordinator arranges case conferences, takes detailed minutes of the meetings, informs the various personnel involved in management of new developments, and reviews and updates the data on all cases in the file.

Three to five new cases are discussed at a two-hour luncheon conference each week. An effort is made to create an atmosphere which is congenial and unintimidating, both for the personnel from community clinical practice settings who come to the hospital to discuss their cases and for the benefit of our own house officers and professional staff, from whom an adequate flow of information on these cases is essential.

Systematic review of the data pertinent to the formulation of management judgments is helped by a short handout on each case, which is prepared in advance by the hospital social worker. The format of the handout is displayed in Table I.

In December 1972, a problem-oriented record keeping system was introduced for Trauma X cases. It will be reported subsequently.

RESULTS

Figure 2 summarizes the Trauma X patients seen at the Children's Hospital in the hospital years before and after the organization of the Trauma X group in September 1970.

Figure 3 summarizes the literal cost of inpatient Trauma X cases at Children's Hospital. With a reduction of the mean hospital stay from 29 to 17 days in the year following the organization of the Trauma X Group, the disproportionate contribution of the day rate to the total cost was changed appropriately, demonstrating somewhat more efficient management by this criterion of effectiveness. (These fiscal data have been particularly useful in contacts with Welfare Department officials and state legislators in an effort to improve services for these families.)

The rates of reinjury among the hospitalized cases in the hospital years before and after the formation of the Trauma X Group are summarized in Table II.

A more sensitive and accurate estimate of the risk of reinjury can be computed by constructing a life table which measures the total number of person-months contributed by the population of cases under observation in a given time interval. Table III displays the results of the life table analysis of the data from the calendar year preceding the formation of the Trauma X Group and for the subsequent year and half-year intervals. The details of the calculation of risk for the periods under evaluation (9/15/69 to 9/14/70, 9/15/70 to 9/14/71, and 9/15/71 to 2/14/72) are shown on Tables IV, V, and VI. Follow-up information complete to May 1, 1972, is included in this table. The tests of significance of these data are summarized in Figure 4.

TABLE VI

LIFE TABLE: 9/15/71 TO 2/14/72

Month After Entry X	*Observed at X*	*Lost Anniversary at X*	*Observed X to (X+1)*	*First Reinjury X to (X+1)*
0-	41	0	41	1
1-	40	0	41	0
2-	41	18	30	0
3-	23	7	23	0
4-	22	15	7	0
5-	7			

	Probability of Reinjury X to (X+1)	*Probability of Survival X to (X+1)*	*Cumulative Probability of Survival to X*
0-	.02	.98	1.00
1-	0	1.00	.98
2-	0	1.00	.98
3-	0	1.00	.98
4-	0	1.00	.98
5-			

Risk of reinjury in the interval = 2%

DISCUSSION

The impression of effectiveness in reducing the human cost of child abuse suggested by the crude rates of reinjury is supported equivocally by the life table data, which are not significant when treated by the standard method.[9] Cautious interpretation of this analysis is indicated, furthermore, because the outcome data are affected by an ascertainment bias comprising three principal elements:

1. Follow-up information was more easily available once the program of regular surveillance began.

TABLE VII

ASCERTAINMENT BIAS

	Effect on Outcome Data (+ = toward better outcome)		
	1969–1970	*1970–1971*	*1971–1972*
Adequacy of follow-up data	+	—	—
Length of follow-up interval	—	+/—	+
Breadth of definition of Trauma X	—	+	+

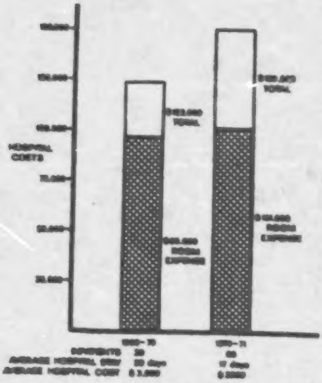

FIG. 3. Hospital expenses, Trauma X inpatients, Children's Hospital Medical Center, Boston, Massachusetts.

TABLE VIII

PRESENTING SYMPTOMS: TRAUMA X CASES

	July 1, 1969, to June 30, 1970	*July 1, 1970, to June 30, 1971*	*July 1, 1971, to March 31, 1972*
Symptoms:			
Bruises	19	17	26
Burns	[illegible]	10	8
Skull fractures	[illegible]	8	10
Other bone fractures	11	8	10
Neglect	15	14	16
Head injuries	6	0	7
Lacerations	4	4	3
Poisonings	1	0	4
Abandonments	0	2	1
Deaths	1	0	1
Inpatients	30	60	61
Outpatients	63	28	69
Total cases	93	88	130

TABLE IX

FOSTER PLACEMENT: TRAUMA X CASES

	1969–1970	*1970–1971*	*1971–1972 (6 months)*
Patients	60	80	[illegible]
Placed in foster care	8	16	[illegible]
Rate	8/60 = 13%	16/80 = 19%	[illegible]

2. Earlier cases have had more time in which to be exposed to reinjury.
3. With increasing diagnostic sophistication, cases with more subtle clinical signs have been included in the index population.

The effects on the outcome data of the bias of ascertainment are summarized on Table VII.

Were children with less serious injuries preferentially selected for inclusion in the series as time went on, the likelihood of reinjury might also have progressively diminished. The nature of the presenting symptoms in the cases in the two hospital years under study indicates that the severity of their injuries did not change. These data are summarized in Table VIII. An indirect inference of the risk to the children in the series may be drawn from the rates at which the judgment was made to separate them from their families. As shown in Table IX, these rates increased slightly. Interestingly, they approximate Kempe's estimate of the number of child abuse cases in which drastic protective intervention, placing children in foster care, is necessary.[10]

There is a discrepancy, however, between Kempe's conception of "the battered child" and our definition of "Trauma X." In his classic paper, Kempe defined the syndrome as follows: "The battered child syndrome is a term used by us to characterize a clinical condition in young children who have received serious physical abuse, generally from a parent or foster parent."[11]

The Children's Hospital euphemism, Trauma X, is defined as a *syndrome with or without inflicted injury, in which a child's survival is threatened in his home.*

This definition focuses on the risk to a child rather than on the *intentions* of a family which has not adequately been able to protect him. In distinction to the process of making a diagnosis of child abuse in the conventional sense, where the *intent* to batter is estimated from contacts with the family, this diagnostic concept tries to measure the capacity of parents to protect their children.

STANDARD ERROR OF RISK:

$$\text{Cum. Surv.} = P_k = p_0 \, p_1 \cdots p_{k-1}$$

$$\frac{\partial P_k}{\partial p_i} = \frac{P_k}{p_i}$$

$$S^2 = V(P_k) = \sum_{i=0}^{k-1} \left(\frac{P_k}{p_i}\right)^2 V(p_i)$$

$$= \sum_{i=0}^{k-1} \left(\frac{P_k}{p_i}\right)^2 \frac{p_i q_i}{n_i}$$

$$= Pk^2 \sum_{i=0}^{k-1} \frac{q_i}{p_i n_i}$$

1969 – 70 $S^2 = .0016$ $P_k = .92$
$S = .04$

1970 – 71 $S^2 = .0012$ $P_k = .93$
$S = .035$

1971 – 72 $S^2 = .0004$ $P_k = .98$
$S = .02$

Sig. tests:

H_0 : there is no difference between ('69 – '70) and ('70 – '71)

$$Z = \frac{.93 - .92}{\sqrt{.0016 + .0012}} = .10 \qquad \text{not sig. } (p = .84)$$

H_0 : there is no difference between ('69 – '70)('70 – '71). and ('71 – '72)

$$Z = \frac{.93 + .92 - 2\,(.98)}{\sqrt{.0012 + .0016 + 4\,(.0004)}} = 1.67$$

not sig. ($p = .10$)

FIG. 4. Life table significance tests.

In making a diagnosis of child abuse, a clinician can use his technical and human skills to identify what has gone wrong in the family's ability to nurture a child and in an unpunitive way to help them solve their problem with him. Furthermore, these data seem to show that a hospital can serve as an effective portal of entry into the child health and welfare service system for disorganized families whose children's lives are in jeopardy.

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BATTERED BABIES:

- Their screams of terror go unheard -

by

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and

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---

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BATTERED BABIES: Their screams of terror go unheard.

INTRODUCTION

Since the term "battered child syndrome" came into popular usage among professionals, what have the actual results of their efforts been? What benefits, if any, have accerued to these helpless frightened children?

In 1946 Caffey described subdural hematomas and multiple bone abnormalities in children as findings of obscure etiology. Unknown to Caffey and the experts, the probable cause of these injuries was physical abuse by the patients' parents or caretakers. These children were sent home where some developed new injuries.[2]

Seven years later, in 1953, Silverman described multiple fractures due to recurrent trauma.[14]

Then, in 1961, Gwinn et al described unsuspected trauma in infancy and stated that "serious injury and even death are not at all uncommon after these infants have been returned to their home environment."[5]

In 1962 Kempe coined the term "battered child syndrome" to describe " a clinical condition in young children who had received serious physical abuse, generally from a parent or foster parent.[10]

INTRODUCTION

Today, 30 years after Caffey's article, the nightmare for these children continues; many battered children are again returned to their original environments where many are battered again, and some die.[1, 3, 12] According to studies, at least 10% die and 30% suffer repeated abuse.

We have selected several case studies from the charts of a major teaching hospital. The admissions for suspected abuse were from late 1973 to mid-1975. These illustrate some of the incredible injustices these children have endured. Most of them are under 3 years of age and too young to speak for themselves. Their names have been changed.

BATTERED BABIES: Case studies.

CASE # 1.

Victor H.

At 5 months of age this child developed his third lower respiratory tract infection. The physician's recommendations, such as the use of a vaporizer, were not being implemented. The boy's mother was a known heroin addict. They lived with a (drug) supplier, who was male, and with two other female addicts and their children. This situation should have been known to various agencies: the mother was on probation for counterfeiting, and the father in jail for burglary.

The first documented incidence of abuse to Victor, on 4/25/74, was when the child was 3 and 9/12 years old. One day the male of the "family"(the supplier) allegedly became angry with the mother and directed his anger against the child by beating him and "grabbing his genitals." Victor was also kicked and "knocked unconscious." On arrival at the emergency room, the boy had fresh lacerations and bruises on his face, thorax and extremities. There were also old scars on the right side of his head, and above the 6th rib. The genitalia were slightly erythematous.

The hospital staff reported this case to Child Welfare. Victor was kept in the hospital for 24 hours for observation. He did well and was discharged to Child Welfare authorities, who were arranging for foster placement.

Several questions arise: How many agencies knew of his situation earlier? What happened to him next - was he returned to his previous setting, as are so many other abused children? And what happened to the children of the other women addicts in the "family?"

CASE # 2.

Bonnie K.

Bonnie"s first visit to the hospital clinic, on 8/24/73, was at age 6 weeks, when she was diagnosed as having viral gastroenteritis. A couple of weeks later her mother brought her back and, according to the chart, the infant allegedly had been beaten with a comb and wires by her father. In addition, the baby had been "allegedly sexually molested per vagina and rectum digitally," in the words of the physician. The mother also reported that the father refused to buy enough formula for the baby.

Bonnie's weight was then only 5 lbs. 8 ounces, the same as her birth weight. The doctor called her a malnourished baby, and described "multiple bruises and small puncture wounds." The impression was, that Bonnie was an "abused child." X-Rays of her skull and long bones showed no fractures, and the mother was advised to return with the child two weeks later.

Not until 6 months later did they return, when Bonnie was treated for facial and vaginal rashes and congestion; she was 8 months old. At 9 months she was seen again for a checkup and given vitamins.

CASE # 2: Bonnie K.

The following month Bonnie was brought in unconscious (5/21/74); it was around midnight when she arrived. Her pupils were large and fixed. She was flaccid and had bilaterally positive Babinski reflexes. X-Ray of the skull showed a linear fracture in the occipital area.

After further studies she was taken to surgery where the blood clots were removed from her head. Her diagnoses were: acute right subdural hematoma and subacute left subdural hematoma. Bonnie died in the recovery room less than 5 hours after she had reached the emergency room.

According to the chart, this baby had been mistreated before. Her mother had come with her on several occasions to the clinic. The doctor there had recognized that the child was abused and neglected, but apparently no arrangements were made to prevent further battering.

Was a full investigation ever made of her death?

CASE # 3.

Denny D.

Denny had been born by Cesarian section to a 16-year-old. He was 4 and 1/2 months old when he was brought to the emergency room with burns and a head injury (5/14/75).

According to Denny's mother, she had left him on a bed while she went for his bottle. From the kitchen the mother heard a thud and a short cry from the bedroom. When she ran into the bedroom, she found that the baby had fallen off the bed. He had landed on his right side, on a radio, with his head hanging to the floor. When she picked him up, he seemed limp, and was unresponsive.

To wake the infant, the mother put him under a faucet. She said that she meant to run cold water over him, but the water was hot and scalded him. She said that the baby did not react at all to the hot water.

On examination, the baby's anterior fontanelle was found to be tense. Arteriography revealed a right infratemporal hematoma. He had a bruise on his right thigh, and 2° burns on his right upper and lower back, both buttocks, and left anterior thigh and foot. His right clavicle was deformed; x-ray revealed an old fracture of the clavicle. The child was alternately lethargic and irritable. (The family denied any previous injuries, or easy bruising.) Denny underwent surgery for the right infratemporal hematoma, and treatment for his burns. His hospital course was complicated, and his condition gradually deteriorated. After 18 days in the hospital, Denny died of complications of the head injury.

It was the impression that Denny had been battered. Was action taken against anyone? Was a full investigation made at all?

CASE # 4.

Bobbie C.

Bobbie was brought into the hospital at age 10 months, on 11/15/74, because of diarrhea and vomiting, and also because of multiple bruises and scratches on his face. According to the mother, these bruises had been inflicted by the child's father when he was "mad because he had lost his job." She alleged that the father beat the child on the head with his fist. She had occasionally noticed bruises on Bobbie ever since his father had returned from the service 6 months earlier. The father usually told her that Bobbie had fallen. Child Welfare was consulted, and they advised that the child be discharged to the parents, and that they would "work with" the family. X-Rays of the skull, chest and long bones were negative at this visit.

Three weeks later Bobbie was brought to the hospital again; his mother said that he had fallen out of bed. When she found him, his mouth was bloody and his right leg swollen. X-Ray revealed his right femur to be broken. This injury happened while Child Welfare was "working with" the family. Bobbie was in the hospital in traction for about a week, then he was put into a cast. He had nightmares, and was afraid of men. His injuries were reported to Child Welfare, who arranged for foster care.

Within 6 months, though, Bobbie was in the clinic again, this time with a swollen right face and neck, cause unknown, a probable viral syndrome. At this time Bobbie was back again with his parents.

How and where is Bobbie now?

CASE # 5.

Linda and Laura M.

Linda was first hospitalized at age 16 months for battering. She was comatose on admission (4/22/74) due to head trauma, and had sustained severe brain injury. In addition to her bilateral subdural hematomas shown on arteriograms, bone series showed her to have an old fracture of the left humerus.

At the time of Linda's admission, her twin sister was brought in for examination and found to have been growing poorly (less than third percentile in weight), and to have what looked like cigarette burns on her labia. X-Rays of the twin revealed old fractures of her right radius and left humerus. Child Welfare was contacted.

After her acute treatment, Linda was transferred to another hospital for three months. She was discharged then to a foster home. Her twin also had been put in foster care, after a brief hospital evaluation. Developmental evaluation of Linda when she was 20 months old showed that she had poor co-ordination and control of her extremities (at the 11-month level), while her language development and social behavior were around the 12-month level. The doctor felt that the child was making good progress, and that her rate of development would accelerate in the following months, as the child recovered from her trauma, and tried to "catch up."

CASE # 5: Linda and Laura M.

She was next seen at the hospital when she was 31 months old. The father had been separated from the family, but she was brought in by her natural mother because of vomiting and diarrhea. The doctor noticed that Linda had multiple bruises on her face, lumbosacral area and extremities. Some of the bruises were fresh and some were old.

Linda spent about a week in the hospital this time. She was again discharged to a foster home. All of her siblings were also placed in foster care; in addition to her twin she had an older brother and sister, and a baby sister (born 4 months after Linda's first hospital admission).

Linda and her twin had been returned by Child Welfare to their parents after they had been so abused as to suffer multiple broken bones and, in Linda's case, severe brain damage. Under the "protection" of Child Welfare, they were battered again. Are they finally safe? Will their parents be allowed to get them back again?

CASE # 6.

Karen B.

Karen's problems were first reported to Child Welfare when she was brought to the hospital with a broken left femur. This was about 10 days before Karen's first birthday, on 9/27/74. The parents said that her stepfather had fallen with her to the bed when he became "dizzy from a cold;" her leg was broken when it got caught between the mattress and the bedstand. Karen also had bruises on her back and on the back of her head. Bone survey showed only one fracture of her left leg.

After about two weeks in the hospital Karen went home. A visiting nurse was to see her weekly. On one visit the nurse noted that the baby had developed impetigo, and that her arm was swollen. The nurse instructed Karen's mother to take the child back to the hospital.

Only after several days did Karen's mother bring her to the hospital. This was six weeks after she had left the first time. X-Rays showed her broken leg to be healing, but in the six weeks that she had been at home she had suffered a fracture of her right radius, and, most recently, fractures of her left radius and ulna.

This time, Karen spent only 4 days in the hospital, then was discharged to a foster home. Before long, however, as before, she was returned to her parents. She was found dead several weeks later, of "accidental drowning."

While under the care of Child Welfare authorities, Karen suffered multiple fractures; 15 months after her first injury she was found dead of "accidental causes." *

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* Information obtained via personal communication of local news reports.

SUMMARY

These six cases (actually involving seven children) illustrate the seriousness of child abuse. One of the authors was on the faculty at the hospital where they were treated - Ben Taub Hospital (Baylor Medical College), in Houston, Texas. These cases were chosen from those which were brought to her attention rather randomly by various - disillusioned? - hospital personnel who happened to know of her interest in the subject, and from sparse, incomplete files. The information presented is taken from hospital charts.

Most of the children involved were under 3 years of age. Except for one (Denny D.), they were known to various authorities prior to these beatings. Four were under the protection of Child Welfare. One was identified by the doctor as a suspected battered child, but not reported, as far as can be ascertained by her chart. Three of the children died. One had severe brain damage. What is the outlook - physically and emotionally - for the others? Their prognoses must be guarded. Where and how are they now? Who is responsible for their well-being?

Our system fails battered children by allowing their abuse to continue. One or more agencies may "work with the families." But again and again they are sent home to be beaten, burned, twisted, stabbed, scalded, starved and sexually molested.

Unfortunately, throughout the country, a significant number of fatally abused children was previously known to some form of authority before their deaths. This report does not reflect the area where these cases take place; but rather represents a nightmare which is national in scope.

CONCLUSION

In the 30 years since Caffey alluded to the enigma of the battered child, what progress has been made? Who is responsible for the repetition of these crimes - the cruel and sadistic treatment of these children is, in fact, a crime - Child Welfare, the hospitals, the doctors, the district attorneys, the courts?

It is true that some of these battered children are removed from their families, but most ultimately go back to their original environments. We worry about their fates. Many will be permanently maimed or retarded. Many will be institutionalized eventually because of severe emotional problems. Many will die.

We feel that in many instances the child must be removed, often permanently, from abusive parents, whether to foster homes, group homes, or for legal adoption. We believe in the rehabilitation of families when possible, but never at the expense of the child's safety. There must, however, be a legal framework to protect the child. It is outrageous to place any segment of the population above the law, especially parents or guardians of children (placing persons who beat or murder children above the law is a disgrace). A three-year-old child should have the same rights as any other citizen of this country.

We feel that:

1) All cases of child abuse should be investigated not only by Child Welfare, but by the proper law enforcement agencies.

CONCLUSION

2) The safety and well-being of the child must come first; no battered child should be returned to his environment without legal representation, and without the specific recommendation of a panel of experts on child abuse.
3) Shelters and group homes need to be provided for these children, with the supervision of persons with specialized training in their needs and care.
4) Programs should be instituted for the detection and prevention of child abuse, as well as courses at the high school and college levels on the responsibilities of parenthood.

New laws are urgently needed for the protection of these children. The injustices committed upon these helpless and frightened children in the past must no longer be tolerated by our society.

ADDENDUM

1) A survey of 71 hospitals presented 302 cases of child abuse during a single year. 33 children died and 85 had permanent brain damage.[10]

2) A long-term study of 50 abused children showed:

   3 died on admission.

   5 died several months after being discharged from the hospital, 2 allegedly "at the hands of their mothers."[3]

3) Another study, a 3-year follow-up of abused children sent back to their homes showed that:

   Approximately 35% were treated in hospitals for neglect or repeated abuse.[12]

4) In 1972 a study by the New York City Task Force on Child Abuse and Neglect:

   Of 54 children who had died of suspected abuse, more than 50% of the families were known to a social service agency before their deaths. 8 of them were known to Child Welfare.[7]

ADDENDUM # 2.

There are approximately 100,000 cases of physical child abuse in the United States each year - this does not include cases of child neglect.

EPILOGUE

An estimated 4,000 abused children die in this country each year.

These children are crying out in anguish for help.

Yet their screams of terror go unheard...

Their screams of terror go unheard...

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A PEDIATRIC ANNALS REPRINT

Knowledge and Epidemiology of Child Abuse: A Critical Review of Concepts

By ELI H. NEWBERGER, M.D., and JESSICA H. DANIEL, Ph.D.

By identifying and clarifying concepts underlying present knowledge of child abuse, this article may provide the reader with critical tools for understanding it. We shall focus on the magnitude of the problem and probe the meaning of present data and practice.

There is reason to question the nature and quality of knowledge about child abuse. Formal recognition of an age-old phenomenon, demonstrated by an enormous increase in the number of official case reports annually since the mid-1960s, has created a difficult dilemma for medical professionals. Notwithstanding a century's experience in the American child welfare movement and more recent medically based contributions from Kempe and others, we have a service system that, despite humane rhetoric, is unable to promote the safety and well-being of many children. This is in large part due to a paucity of such essential family supports as counseling, medical, homemaker, child-care, and nursing services and to a heavy reliance on

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foster-home care. A tightfisted social policy toward families and children ($2.5 billion for child welfare each year since 1972 in the face of two-digit inflation and expanding demands for service) means, simply, that when a professional person files a child-abuse case report, the services that follow may be incapable of dealing with the needs of family and child.

Inadequate or incomplete service is only part of the problem. Our basis for practice is flimsy. We have a commonly accepted humane philosophy (if not in reality programs that can translate that philosophy into humane action): to protect parents and children from repeated physical consequences of family crisis. But because we lack a solid theoretical and practical understanding of the origins of child abuse, our clinical work is at best intuitive and kind, at worst reflexive and mean. We read a literature in each of the professions characterized by homilies, bromides, and few scientific investigations of substance. And we look at child abuse as a phenomenon originating in the psychology of individuals, frequently ignoring the social and cultural realities that frustrate our treatment of particular families and impose formidable obstacles to the prevention of child abuse.

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Because of the contradictions between philosophy and practice and our incomplete knowledge, we find ourselves wondering whether the following are unanswerable questions when cases of child abuse are identified: Is the child at risk? Can the family be helped? Are competent intervention resources available? Will I do more harm than good by reporting the case?

We do not mean to suggest that the clinician should throw up his hands in despair when the next case of child abuse is brought in. Within the framework of existing knowledge and resources, possible answers and helpful clinical guidelines can be drawn up, and these are the subject of a recent review.[1] By presenting a glossary of concepts and pertinent current data in this article, we would like to help foster an informed and more logical response to child abuse.

"CHILD ABUSE," "CHILD NEGLECT," AND "ACCIDENTS"

Definitions of child abuse vary, from Kempe's "battered child syndrome,"[2] which identifies injuries inflicted by care givers; through Fontana's "maltreatment syndrome,"[3] which includes child neglect; to the current Office of Child Development model reporting statute,[4] which embraces many physical and emotional symptoms attributable to parental failure; and to Gil's concept of any force that compromises a child's capacity to achieve his physical and psychologic potential.[5] Virtually all definitions identify the child as victim, and most identify parent or family as perpetrator.

Important *value* concepts are built into the vocabulary, and in the words themselves are postulated etiologic mechanisms that logically imply diagnostic and intervention procedures. The names "battered child syndrome" and "maltreatment syndrome" have strong implications. They indicate that a child's injuries were caused by his care giver, either actively or passively.

To make such "diagnoses" requires an investigation to determine whether or not there is parental culpability. Inquisitions of parents to ferret out the facts have been characterized by some as clinically unhelpful, ethically absurd, and intellectually unsound.[6,7] Faced with ambiguous data, conflicting accounts of how the child may have received his injuries, and a need to make a definitive diagnosis, the clinician may find himself playing a detective game for which he is professionally unprepared.

Stoked by the strong feelings that child-abuse cases promote in all of us, the diagnostic process may further alienate an isolated, frightened, and confused family and fulfill the preconception of parental failure: aggressive inquiry eliciting evasive response, angry affirmation of suspicion leading to confirmed diagnosis, and subsequent estrangement of family from clinician and separation of child from family.

Different professional people respond in different ways to the personal and ethical conflicts imposed by contact with troubled families. Some physicians find it difficult to believe that parents could injure children. Many characterize all children's injuries as "accidents" (the term connotes an isolated, random event).

Although traumatic injury to chil-

495

dren is the major cause of morbidity and mortality after the first year of life[8] and is predictably associated with familial and child developmental crises,[9-11] the nature and organization of child health practice do not usually permit exploring and acting on the causal antecedents of childhood "accidents." Physicians and nurses may not have the time to interview parents or to make detailed child development observations, and such backup diagnostic services as social work and psychiatry are most often situated in separate institutions and practice settings. No treatment other than of the presenting symptom is implied by the diagnosis of an "accident."

Further, because of the onerous significance of making a judgment that a particular family is "abusive" or "neglectful," it is often easier to ignore these "diagnoses." The finding that the great number of reported victims of child abuse are poor[12] and disproportionately represent ethnic minority groups suggests that the more heavily value-laden diagnoses for childhood traumatic injuries (child abuse and neglect) are made more easily when the clinical setting is public and there is great social distance (social class or ethnic discrepancy) between clinician and family.

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We clearly need a more scientific taxonomy of childhood "social illness," one that would organize clinical data in such a way as to stimulate helpful and effective practice. Until we have it, however, we shall have to labor with the existing words.

CHILD-ABUSE EPIDEMIOLOGY

The number of annual child-abuse case reports in the United States has jumped from about 7,000 in 1967[13] to over 200,000 in 1974.[12] To understand the significance of this impressive increase for clinical practice requires the explanation of a few simple concepts.

Incidence. This is the number of events in a defined interval or, for purposes of the present discussion, in a year.

Prevalence. This is the number of phenomena that exist at a particular time.

Duration. This is the length of the phenomenon.

A simple equation expresses the relationship of incidence, prevalence, and duration: Prevalence (P) varies as incidence (I) times duration (D) or, more simply, $P = ID$.[14] (This assumes constant flow of information, or a "steady state," into the system.) Although we are accustomed to thinking of the magnitude of the child-abuse problem in terms of the number of new case reports received each year, it is well to remember that these reports flow to human-service institutions (generally welfare departments) with finite capacities to deal with them. The prevalence of cases already "on the books" is a principal reason why the system bogs down.

Suppose, for the sake of discussion, that the duration of the typical child-abuse case, from diagnosis to resolution of the family problem, is 2.5 years. (This figure obscures the great variety of family situations that present as child abuse and, to be sure, minimizes the continuing, developmental impact of child abuse recently emphasized by Martin and his colleagues.[15] Also, protective-service agencies follow few cases for this long. Take it as an arbitrarily selected number.) For 1967, then, an estimate of the prevalence of child abuse is $7{,}000 \times 2.5 = 17{,}500$. For 1974, the prevalence may be estimated as $200{,}000 \times 2.5 = 500{,}000$.

These estimates may bear little relation to reality, but in the unfortunate absence of reliable data on actual recorded prevalence,* they provide an impression of the extraordinary burden that child welfare institutions are now shouldering. In the face of a rising number of case reports and the essentially fixed ability of the service structure to deal with them, there is an unavoidable risk that a case may not be acted on. Or, perhaps worse, precipitous, uninformed protective-service action may separate a child from his family unnecessarily in the interest of his physical protection. So, when one sees a case of child abuse, one must assure that the case report is followed by sustained, helpful action.

Sampling bias. Some people are much more likely than others to be

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* It is hoped that this situation will soon be remedied by the new National Center on Child Abuse and Neglect in the Office of Child Development in Washington, which has a specific Congressional mandate under Public Law 93-247 to report annually on the size of the child-abuse problem.

discovered as child abusers. Members of ethnic or economic minorities are particularly susceptible. This fact skews the findings of any survey or study towards the attributes associated with the group to be studied. Poor families and ethnic minorities appear with special frequency in child-abuse case rosters and studies. This has in part to do with the dynamics or practice, as was pointed out above.

The pertinence of the findings of any investigation to the experience of the general population from which the study subjects are drawn depends on the investigator's ability to account for whatever selective forces operate to include some and not other members of the population.

Our increasing comprehension of the personal and ethical dilemmas that go into making a diagnosis of child abuse inclines us to believe that as long as we persist in studying phenomena with such negative labels as "child abuse" and "neglect," we will not be able to control the biases favoring the selection of poor and minority families in our samples. (The foregoing is not to deny the extent to which the exigencies of poverty are associated with physical and psychologic stress in families, which in turn may be expressed in violence or neglect toward children.[17-19])

Confounding. Here, because of the investigator's inability to control an intervening, perhaps unforeseen, variable, a spurious association is mistaken for a causal relationship.

Confounding can be reduced (although seldom completely avoided) by controlling studies with matched comparison groups. A striking example of confounding in the recent child-abuse literature is found in the British study by Smith and colleagues.[20] The authors noted an impressive increase in the prevalence of psychologic problems in the parents of abused children. This finding, however, may be an artifact of the different socioeconomic groups from which the cases and "controls" were drawn. Since social class and psychologic symptoms are associated,[21] one cannot assert that there is a primary relationship between psychologic symptoms and child abuse. This finding is "confounded" by social class. The confounding would have been reduced by "matching" cases and controls on social class. This would "control" the confounding variable.

The concepts of sampling bias and confounding are of particular importance in regard to the postulated association between child abuse and later adult deviant behavior, which Schmitt and Kempe have underlined vividly in the most recent edition of Nelson's *Textbook of Pediatrics*.[22]

> If the child who has been physically abused is returned to his parents without intervention, 5 per cent are killed and 35 per cent are seriously reinjured. Moreover, the untreated families tend to produce children who grow up to be juvenile delinquents and murderers, as well as the child batterers of the next generation.

The truth of such assertions will have to be weighed by a careful consideration of the data from which they derive. Those socially marginal people who are most susceptible to having their children's injuries characterized as having been "abusively" or "neglectfully" obtained are also those whose adult behavior is most likely to be labeled "criminal."

This is not to minimize the importance of the developmental sequelae of child abuse. Rather, we urge critical and serious attention to the meaning of our professional language and knowledge, the better to develop a vocabulary of words and tools that will more adequately help children and families in distress. ☐

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The Myth of the Battered Child Syndrome

Focus on parents' inability to nurture child.

RECENT WORK on childhood accidental injuries leads us to a more enlightened conception of child abuse from the one implied in the diagnosis of "the battered child syndrome," to a more humane view which focuses on the parent's capacity to protect a particular child rather than any "intent" he may have had to injure him. Studies by J. D. Holter and S. B. Friedman (*Pediatrics, 42:* 128, 1969), G. S. Gregg and E. Elmer (*Pediatrics, 44:* 434, 1969), and R. Sobel (*Pediatric Clinics of North America, 17:* 653, 1970) demonstrate that there is a common causal background behind childhood accidents—so called "intentional" accidents and otherwise—which has to do with a variety of real life as well as psychologic factors, including poor, crowded housing, accessible hazards, low social class, large family size, alcoholism and drugs, illness, prematurity, and unemployment.

We are coming to see that the essential element in child abuse is not the intention to destroy a child but rather the inability of a parent to nurture his offspring—a failing which can stem directly from ascertainable environmental conditions which may not necessarily be accessible to the intervention of social workers, physicians, nurses, psychiatrists, and others who offer the traditional modalities of care to distressed families.

When we at the Children's Hospital in Boston reformulated our definition for *trauma X*, our house euphemism for child abuse, we decided to define this diagnostic entity not as inflicted injuries brought on defenseless children by willfully destructive parents, the concept implicit in the "battered child syndrome" diagnosis, but as an illness, with or without inflicted injury, stemming from situations in his home setting which threatened a child's survival.

Francis Sargent, the Governor of Massachusetts, convened an advisory committee on child abuse which proposed a similar definition, also intended to be compassionate and nonpunitive. The definition read as follows: "a family crisis which threatens the physical or emotional survival of a child." The object was to define

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Condensation of "The Myth of the Battered Child Syndrome: A Compassionate Medical View of the Protection of Children," by Eli H. Newberger, M.D. Paper presented in a panel discussion, "The Medical Aspects of Child Abuse," at the 95th Anniversary Symposium, American Humane Association, October 1971.

in a helpful way where intervention is to be directed; to identify the causes of the problem (which are nearly always multiple and very rarely stem from simple, destructive intent of a parent which you can see); to focus less on the symptoms of the child than on what problems seemed to lead to those symptoms; to allow one to commit one's resources in such a way as to exert some positive impact on the family's ability to prevent them from happening again.

Each individual medical practitioner, or center, has to work at his own style of management. The model which we have been introducing in Children's Hospital over the last year has a basic idea, *i.e.*, to come to grips with the complexity of each case and to tackle its specific important components directly. There is, of course, an important relationship between the personnel who are providing care and those who are receiving it. It may be, however, that effective, lasting intervention is less a function of successful treatment relationships than a matter of defining and resolving specific problems of parents' lives, problems such as poor health, inadequate housing, no child care, and legal and monetary difficulties. Our primary function may be improving, to the extent that we can determine, what Julius Richmond (*American Journal of Public Health, 60:* 23, 1970) has called "a family's ecology of health." This means, for a physician, a somewhat different professional role from his customary one. It means, for us at the Children's Hospital, becoming advocates for these children and families. It means cooperating constructively with our colleagues in public and voluntary agencies to reach the objective which concerns us all, enhancing a family's capacity to care for its children.

For us, creating an interagency, multidisciplinary consultation group with weekly meetings at the hospital has worked well. We meet together to explore the needs of the 3 to 5 children who are referred to us each week bearing physical symptoms of severe family distress. We try to help families function better by finding services which will make a difference in their ability to be parents. These services include medical, dental, social services, legal help, child care, homemaker services, psychiatric treatment, and, very often, haggling on their behalf, with landlords, the police, and the welfare department.

Our ability to intervene effectively is challenged by many situations where one cannot simply offer services, but where one has to go out, find the people, and effectively change the environments where they live before they can come to grips with their problems of nurturing their children. The ethical and political implications of this kind of professional activism have been explored in the recent social work literature by Martin Rein (*Social Work, 13:* April, 1970) and in the medical literature by Julius Richmond (*Pharos, 35:* 17, 1972).

Even when more adequate resources become available, many of the current problems of management will persist. Not the least of these are the exceeding difficulties which public welfare departments are having in coping with dramatically increasing numbers of reported cases. In Boston, for example, the inflicted injury unit of our Division of Child Guardianship, at the time of this writing, has an uncovered backlog of 35 new cases. And in Massachusetts under current law, only bona fide battered babies get reported by doctors. This is a situation which will grow worse when we have better reporting laws.

In New York, the problem was utterly out of control until a few spectacular murders galvanized the community to action. Mayor Lindsay appointed a task force, the report of which is available from his office. Inasmuch as Mayor Lindsay's task force report underlines the need for 24-hr. intervention, a child abuse registry and adequate coordination between public and private agencies, this report is a useful document. Many of its recommendations were heeded, with a resulting upsurge in case reports, as well might be expected. Still, however, the New York City Mayor's Task Force Report pins the blame on the parents and touts the old "battered child," "inflicted injury" jargon as the key to the understanding and control of the problem of children in jeopardy in their own homes.

Governor Sargent's committee report, on the other hand, emphasizes that the way to prevent such a tragic symptom of family distress as child abuse is to strengthen family life. Its recommendations include a dial-a-parent hotline for families in crisis, the coordination of human services with a view to maintaining physical and emotional health, as opposed to treating artifacts of disease, as well as other specifically "protective" services such as a registry, legal services, and more action-oriented case workers.

Functions of welfare departments in child protection are unfortunately tarred by the same brush as their relief and medicaid functions when the time comes for legislative scrutiny of budgets. There is also more than a suggestion that their child protection activities may convey many of the same values toward the poor, or toward people in trouble, as do their relief policies, such as taking their children away as the final "protective" service.

Two superb, book-length analyses of welfare have come out recently, and a citation from each one may help us see how the agencies to whom we physicians have to report cases of child abuse may themselves be part of the problem, which in my view is a profound deficiency in our public policy toward children and families who need help.

G. Y. Steiner, whose book *The State of Welfare* (Brookings Institution, 1971) has a brilliant chapter called "Tireless Tinkering with Dependent Families," makes it plain that Welfare Departments mess around with some aspects of poverty but have an investment in maintaining it. He quotes Representative Martha Griffiths describing a mother's life on welfare:

> "Can you imagine any conditions more demoralizing than those welfare mothers live under? Imagine being confined all day every day in a room with falling plaster, inadequately heated in the winter and sweltering in the summer, without enough beds for the family, and with no sheets, the furniture falling apart, a bare bulb in the center of the room as the only light, with no hot water most of the time, plumbing that often does not work, with only the companionship of small children who are often hungry and always inadequately clothed—and, of course, the ever-present rats. To keep one's sanity under such circumstances is a major achievement, and to give children the love and discipline they need for healthy development is superhuman. If one were designing a system to produce alcoholism, crime and illegitimacy, he could not do better.

One could also do no better to design a system to make parents fail. Insofar as our established "service" structure in public welfare departments allows these conditions to persist, Steiner demonstrates, our human service system is implicated in many cases of child abuse and neglect.

F. F. Piven and R. A. Cloward's *Regulating the Poor* (Pantheon, 1971) develops a historical argument to show that "relief policies are cyclical—liberal or restrictive, depending on the problems of regulation in the larger society with which government must contend . . . this view clearly belies the popular supposition that government social policies, including relief policies, are becoming progressively more responsible, humane and generous." The authors document several situations where the threat of applying "protective services" has been used to intimidate welfare rights demonstrators. This is a scary and impressive scholarly work to which we professionals interested in salvaging families and protecting children should attend.

We physicians face a dilemma with respect to cases of child abuse. We have an ethical obligation to intervene in situations where a child's life may be in danger. Yet the technologic tools of intervention can be incompetent or destructive. Fortunately, there is evidence that specific, vigorous activity directed at the causes of an individual family's particular crisis can make a difference in the safety of a child in jeopardy.

Physicians and medical institutions can work toward making public agencies' activities with regard to children more adequate to the task of sustaining families. Just as I think we should reject the punitive taxonomy of illness which fixes the blame for a child's injuries on his parent (because it makes no scientific sense and doesn't help in case management) I think we can offer cooperation, consultation, and support to the personnel in public protective agencies. This could lead, ultimately, to a coherent and humane approach to the control of child abuse. The crux of the matter is that child abuse is a complex phenomenon which requires the investment of diverse and coordinated professional energies. It is a symptom of distress in a complicated family ecosystem with many interacting variables. To recognize and act appropriately on the really important ones requires more than simple definitions and isolated professional activities.

Children's Hospital Medical Center
Boston, Massachusetts

AMA SYMPOSIUM - THE BATTERED CHILD

STATEMENT

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Chairman of the Mayor's Task Force on Child Abuse
and Neglect

Child abuse is a violence perpetrated by society upon its children, it is a symptom of the violence running rampant in our country today. Child abuse and neglect in all its aspects denotes social disorganization that results in the creation of hard-core criminals, drug addicts, and battering parents that perpetrate the cycle of "violence breeding violence". The most important single social implication of this disease is that these abused and neglected children, if they survive, will be scarred with emotional and psychological crippling which is passed on to succeeding generations with a sense of rejection, frustration and anger which ultimately leads to crime and violence.

The battering parents are often lonely, immature, impulsive, suspicious, untrusting, angry people with a multitude of problems and involved in drugs, alcohol, marital and financial stresses. They display great resistance and outward objections toward treatment and assistance. They lack basic trust but do have within them a strong need for help.

The magnitude of this unbelievable tragedy is not being appreciated or accepted by our society and the masses are unaware of its existence. This insidious epidemic of child abuse can only be stopped when people will allow it to be brought into the open and the masses of people realize the scope of the problem and the implications its carries for the individual and his family.

We as a nation cannot pretend that child abuse, neglect, and battering does not take place, or that it is rare, or that it is limited to the people in the ghettos and slums, or that only parents with mental disease batter their children. Unfortunately, all these feelings are false and the disease is far from being rare. In New York City alone in 1972, over 200 children died of maltreatment. In New York City this year it is estimated that over 15,000 cases of child abuse and neglect will have been reported to the Central Registry. These cases are those that surface and are reported. There are countless thousands of other children being maltreated that are not being helped or salvaged.

According to the National Center for Prevention and Treatment of Child Abuse and Neglect in Denver, Colorado, as many as 60,000 children are abused and neglected annually in the United States.

Taking into consideration the increase of suspected cases of child abuse, it is estimated that we will be dealing with a minimum of 1.5 million cases of suspected child abuse and neglect this year, approximately, 50,000 childhood deaths that could be attributed to maltreatment and 300,000 permanently injured children - both physically and emotionally.

The American Medical Association has recognized the importance and urgency of the problem by presenting this Symposium on the battered child at its annual meeting.

Information presented by the speakers will bring our present day knowledge of the causes, prevention and treatment of child abuse and neglect to the attention of the medical, social, and legal professions as well as to the masses.

If these people do not bear witness to the tragedy of this social disease and protect the practice with their silence they will be at the same time becoming a party to the needless suffering and unnecessary death of children.

CHILD BATTERING

Vincent J. Fontana, M. D. *

It is difficult to accept the fact that in our society today inhuman cruelty to children appears to be rapidly increasing and that the perpetrators of these crimes are for the most part, not strangers, but the parents themselves.

At least 700 children are killed every year in this country by their parents or surrogates. In 1972 in New York City alone, 54 dead children were reported to the New York Central Registry - - their deaths attributed to parental maltreatment. The Medical Examiner's office reported 48 child homicides; 150 children's deaths attributed to a party other than the parent, bringing the total number of deaths due to probable abuse up to approximately 200 in New York City alone. These statistics strongly suggest that child battering is probably the most common cause of death in children today, outnumbering those caused by any of the infectious diseases, leukemia, and automobile accidents.

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Thousands more are permanently injured, both physically and mentally.

In New York City in 1972 there was more than a 500% increase in reported cases of abuse and neglect within the period of 1961-1970; and in 1972 over 10,000 cases of suspected child abuse and neglect were reported to the Central Registry. Thousands more are being maltreated throughout the United States ranging from gross neglect including starvation to cruelty resulting in emotional and physical damage to the child.

Child abuse is a medical-social disease of epidemic and endemic proportions, a violent child-rearing pattern which is becoming more entrenched in our population. Child battering is a symptom of the violence running rampant in our society today. This generation's battered children, if they survive, will become the next generation's battering parents. Many of the hard core criminals and murderers in our society were themselves products of a home in which parental action was one of child abuse and battering. Child abuse therefore is not only a time-limited phenomena, but rather the cause and effect of a cyclical pattern of violence reflected in all statistics on crime.

The most important aspect of this disease is that these abused and neglected children who survive, suffer future emotional and psychological crippling which is passed on to succeeding generations leading to further crime and violence. Therefore, treating the symptom of the maltreated child is the only means of preventing not only the death of a child but also a means of preventing the "violence breeds violence" cycle responsible for this potentially fatal disease of children.

Children are injured and killed by their parents with calculated finesse behind closed doors and shuttered windows. On record there are thousands of childhood deaths attributed to "sudden infant deaths", "falls", strangulation, suffocation, burns, starvation, "maternal deprivation", sexual assaults, and gross battering.

In 1962, Kempe described the reported physical abuse to children and coined the term "battered child syndrome".

In 1963, we reported our observations on a large number of children who presented with no obvious signs of being "battered" but who had multiple minor physical evidences of parental neglect and abuse. We suggested the term "maltreatment syndrome" be applied to describe this greater whole picture of child abuse ranging from the simple undernourished infant reported as "failure to thrive" to the "battered child" which is often the last phase of the spectrum. In these cases, the diagnostic ability of the physician coupled with community treatment and preventive child abuse programs can prevent the more serious injuries of inflicted battering that are significant causes of childhood deaths.

The maltreated child is often taken to the hospital or private physician with a history of "failure to thrive", poor skin hygiene, malnutrition, irritability, a repressed personality, and other signs of obvious neglect. The more severely abused children are seen in the emergency room of hospitals with external evidences of body trauma, bruises, abrasions, cuts, lacerations, burns, soft tissue swellings and hematomas. Some are seen with an explained ruptured stomach, bowel, or liver. Some are seen with extreme symptoms of the "maternal deprivation syndrome", wherein a mother allows a child to suffer effects of deprivations that lead to physical and mental retardation. Most recently, hypernatremic dehydration, following periodic water deprivation by psychotic mothers, has been reported as a form of child abuse. Inability to move certain extremities because of dislocations and fractures associated with neurological signs of intracranial damage are additional signs of inflicted trauma. Children manifesting maltreatment give evidence of one or more of these complaints. Those with the more severe maltreatment injuries arrive at the hospital emergency room in coma, convulsions or dead on arrival.

Maltreatment of children by parents may occur at any age with an increased incidence in children under 3 years of age. A large percentage being in the under six months of age group. As the age of the child increases, the incidence of child abuse decreases. One parent, more often the mother, is the active batterer and the other parent passively accepts the battering. The average age of the mother who inflicts the abuse on her children has been reported to be about 26 years; the average age of the father is 30 years.

Their lives are marked with divorce, paramour relationships, alcoholism, financial distress, poor housing, recurring mental illness, mental retardation, and drug addiction. These stress factors all play leading roles that cause the potentially abusive parent to strike out at a special child during a crisis situation. The problem of child abuse is not limited to any particular economic, social, or intellectual level, race or religion. However, the battering parents' behavior appears to have roots in their own childhood experiences. The parents' own lack of love, support and protection makes them unable to give love, affection and "mothering" to their own children.

In the last decade, this most pressing problem of child abuse has been recognized by society; however, a reluctance on the part of the physician, traditional yielding to parental authority by the courts, over-lapping of investigation by social service agencies, inadequate training of social workers and allied personnel in the field of child abuse, and very poor communication between the various disciplines responsible for protecting the abused child has resulted, in some cases, in the lack of protection for the abused and neglected child and has given an opportunity to the battering parents to continue these vicious actions that oftentimes lead to death of an innocent child.

The doctor has one of the most difficult roles to play in dealing with the abused child. His first and foremost responsibility is to the child and his family. All of us who have handled battered children over the years have seen unfortunate situations where the family doctor is unable to fulfill his role and yet unwilling to ask for help. It is the child who suffers. When a child is returned home prematurely by a welfare worker or a judge inexperienced in this field, death or severe injury usually ensues.

When the infant or child is taken to a physician or hospital, the history related by the parents is often at variance with the clinical picture and the physical findings noted on examination of the child. The physician often discovers that the mother has taken the child to various hospitals and doctors in an effort to negate any suspicion of parental abuse. Difficulty in obtaining any type of history is often encountered and diagnosis is dependent on the physical examination, x-ray findings, and a high index of suspicion on the part of the physician.

Every medical center should have a child abuse committee providing a readily available team of consultants, headed by a capable pediatrician, to assist the house staff, a psychiatrist, a social worker and hospital administrator. This team must also assume the role of educating their colleagues as well as the members of allied fields in the community.

Once the injury has occurred, the physician's first and immediate responsibility is to the child. When the parents bring their abused or neglected child to the physician, early diagnosis and treatment is essential. The main reason for admitting the child to the hospital other than for assessing the degree of injury is to protect him. It should be a straight-forward admission for the purpose of evaluation. The medical and physical evaluation of the child must be handled thoroughly and expeditiously. Emergency care is often required if the child is acutely ill.

Every child who has a serious unexplained injury should have x-rays of the long bones, ribs, and skull. This is the physician's most important diagnostic tool. The x-ray findings oftentimes speak for the child.

X-rays of the patient's fractures may present in various stages of reparative changes. On the other hand, if no fractures or dislocations are apparent on examination, bone inury may remain obscure during the first few days after inflicted trauma. In these cases, bone repair changes may become evident days after the specific bone trauma. For this reason, x-rays should be repeated approximately 5 days to 7 days after the suspected inflicted trauma in order to evaluate the presence of special diagnostic radiologic findings, related to inflicted trauma to the bones. These unusual bone changes on x-ray include metaphyseal fragmentation, "squaring" of the long bones, periosteal hemorrhages, periosteal calcification, presence of bone fragments, epiphyseal separations, and periosteal shearing.

It is also most important for the physician to take photographs of the body injuries at the time of admission to the hospital. Colored photos are most helpful in documenting findings to various law enforcement agencies and the courts after definitive diagnosis. When the medical and surgical evaluation has been completed the physician is confronted with the difficult task of gathering all the data together and making a definitive diagnosis.

The physician should talk with the parents and work with the house staff. The social worker can enter the picture after the immediate medical evaluation has begun and assist in communicating with the appropriate child caring agencies. The pediatrician on the team should be responsible for completing in detail the necessary child abuse reports mandated under the law. Care must be taken not to eliminate the house staff from the care of the child. Court testimony should be given by the staff physician, not the resident, since experience in this area is essential. With this type of appropriate intervention physicians can protect children's lives, identify the parent or family responsible for child abuse and thereby assist in breaking the chain of abuse which is perpetrated from generation to generation.

In summary, the physician's responsibility in suspected cases of child abuse and neglect should include:

1. Making a suspected diagnosis of maltreatment.
2. Intervention and admission of the child to the hospital.
3. Assessment - History, physical examination, skeletal survey, photographs.
4. Reporting of case to the appropriate Department of Social Service and Child Protective Unit or Central Registry.
5. Request Social Worker Report and appropriate surgical and medical consultations.

6. Conference within 72 hours with members of the Child Abuse Committee.

7. Arrange Program of care for child and parent.

8. Social Service follow-up.

Efforts have been made throughout the country to protect the abused or battered child by the enactment of child abuse laws in every state of the nation. Fundamentally these child abuse laws are only the first step in the protection of the abused and neglected child. It is what happens after the reporting that is of the utmost importance. A multidisciplinary network of protection needs to be developed in each community to implement the good intention of these child abuse laws. It is the physician's duty not only to report suspected cases of child abuse but also to initiate the necessary steps to prevent further maltreatment to the patient and other siblings in the family unit. We must become intimately involved in the social and legal actions taken to protect the child and assist in the treatment of the parents. The purposes of the child abuse laws are to protect the parents when presented with invalid evidence; to protect the child by making it mandatory for physicians to report suspected cases of maltreatment; and to protect the physician involved by legislation that prevents possible damage suits by the parties involved.

Human apathy and indifference in the face of cruelty to others especially children, is hardly a new phenomenon. The great majority of our people have not recognized the rising incidence of child abuse in our society. Politicians tell themselves that it is far better to moderate an illness in our society and try to do something about it from the inside, and that one man's doing cannot make a difference. This may or may not be true. Whatever the answer, it does not relieve us, as physicians, of our responsibility to find solutions. Apparently in this disease there are no miracle solutions. However, the social and psychological aspects of child battering cannot be overlooked. Treating the parent who neglects, batters or kills a child is totally inadequate unless it is coupled with a simultaneous concern to insure future adequate rehabilitation and preventive measures that will help eliminate the psychological and social environmental factors that foster the battering parent syndrome. If these parents are to be given any help they must be made to recognize their own intrinsic worth and potential as human beings. This can only be accomplished by a recognition and cooperative effort by all child caring professionals, and paraprofessionals. Only in this way can we provide the kinds of innovative treatment programs that will help eradicate this disease of child abuse in our communities.

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CHILD ABUSE

JEAN YAVIS JONES
Education and Public Welfare
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April 2, 1975

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TABLE OF CONTENTS

Page

I. Child Abuse in the United States 1

II. The Child Abuse Prevention and Treatment Act (P.L. 93-247) 9

A. Brief Description 9

B. Implementation of Act 9

C. Regulations 11

D. Text 17

III. Selection of Recent Articles 21

A. General Information 21

B. Child Abuse and the Law 41

C. Treatment 57

IV. Annotated Bibliography 69

I. CHILD ABUSE IN THE UNITED STATES

Ironically, it may very well be the abhorrence of child abuse which has made it such a slow-moving area of both Federal and State legislation. The very idea that a parent, who is supposed to love and protect his offspring, could be responsible for his or her child's physical injury, or even death, is so repulsive that many are reluctant to believe it. Our courts and legislatures have also been reluctant to get involved in internal family government, preferring to let the families determine their own laws and punishments. The implied "hands-off" policy followed by the government owes much to our close association with English Common Law. Under this Common Law, the right of the father to custody and control of his children was considered virtually absolute, even where this was at odds with the welfare of the child. This has carried over to some extent in our own legal system.

Early History of Child Abuse in the U.S.

In colonial America, the father ruled both his wife and his children. Parental discipline was severe, and parents, teachers and ministers found justification for stern disciplinary measures in the Bible.

Legally speaking, the early American child was, in fact, little more than the property of his parents. It was not unusual for a child to be bound out to other households as an indentured servant or apprentice. The shortage of labor in colonial America, as well as the strongly pervasive Puritan work ethic, was reflected in early laws. In 1642 a Massachusetts statute required parents and masters to provide for the "calling and imployment [sic] of their children."[1/]

Early laws made a distinction between apprenticeship and servitude (the former requiring training in a trade) but this was not always followed. Eventually, two forms of apprenticeship evolved. Under a voluntary apprenticeship, the child and his parents entered into an agreement on their own initiative. The other form,

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[1/] Order of the General Court of Massachusetts, 1642, Massachusetts Records, II (1853): 8-10.

compulsory apprenticeship, resulted from the practice of binding out dependent children, who had little or no say in the choice of their master or trade. As time went on laws were passed prohibiting the binding out of infants, but the practice of binding out children beyond infancy continued.

The earliest recorded trial case of child abuse involved a master and his apprentice.[2] In Salem, Massachusetts, in 1639, a man by the name of Marmaduke Perry was arraigned for the death of his apprentice. The evidence given stated that the boy had been ill-treated and subject to "unreasonable correction" by his master. However, the boy's own charge that his master had been responsible for the fracture of his skull (which ultimately resulted in his death) was called to question by testimony that he had told someone else that the injury was the result of falling from a tree. The defendant was acquitted.

In 1643, a master was executed for causing the death of his servant boy,[3] and in 1655 in Plymouth a master was tried and "was subsequently found guilty of manslaughter and ordered 'burned in the hand' and all his goods confiscated."[4] Other early recorded cases show the masters of servant children being admonished for abuse and in some cases the children being freed from indenture because of ill-treatment. In 1700, Virginia issued specific laws for the protection of servants against mistreatment.

As can be seen, most of the early recorded cases of child abuse were specifically related to offenses committed by masters upon servants and did not reflect any movement toward protecting children from abusive treatment by their own parents.

2/ Winthrop, John. The History of New England from 1630-1649. J. Savage, ed. Boston, v. 1, 1853: 318-319.

3/ Rev. John Eliot's Records of the First Church in Roxbury, Massachusetts. Sixth Report of Boston Record Commissioners, Boston, 1881: 187.

4/ Children and Youth in America: a Documentary History 1600-1865. R. Bremner, ed. Cambridge, Massachusetts, Harvard University Press, v. 1, 1970: 123.

Whatever court action there was involving family matters was limited to the removal of children from "unsuitable" home environments. "Unsuitable" usually referred to the parents not providing their children with a good religious upbringing, or refusing to instill in them the value of the work ethic. There were two cases in Massachusetts in 1675 and 1678 in which children were removed because of "unsuitable" homes."[5] In the first case, the children were removed because the father refused to see that they were "put forth to service as the law directs."[6] The second case gave similar justification for the removal of the children, with that offense being compounded by the refusal of the father to attend church services.

The removal of children from such "unsuitable" home environments did not reflect any concern about the physical abuse of children and, in fact, may have been responsible for putting them into a more potentially dangerous environment. It was a common practice for children who were dependent upon public support to be bound out. These children would be auctioned off to the lowest bidder, who would then accept his payment from public funds and take the child as a servant or apprentice.

In the larger cities where the problem of poverty was greater, dependent children were put into almshouses. Conditions in these public poorhouses were bad enough for adult paupers, let alone young children. It was not until the beginning of the nineteenth century that major efforts were made to provide separate residences for children, and it was not until then that public recognition of the abuse of these children in institutions was noted.

The dearth of recorded family child abuse cases in early American history suggests the general tendency of the courts to allow parents their own discretion in determining the kind and degree of home discipline. Parents were considered immune

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5/ Ibid, p. 41-42.
6/ Ibid, p. 41.

from prosecution unless the punishment was beyond the bound of "reasonableness" in relation to the offense, or excessive, or the child injured permanently.7/

In 1840, there was a criminal case in Tennessee which involved parental prosecution for excessive punishment. "The evidence showed that the mother struck the child with her fists, and had pushed her head against a wall and that the parents had whipped her with a cowskin, tied her to a bedpost with a rope for two hours, and switched her. The court reversed the parents conviction holding that whether punishment was excessive was a question of fact for the jury to decide rather than a question of law."8/

Early Reform Movements -- Children as Animals

It was not until the second decade of the nineteenth century that public authorities began to intervene in cases of parental neglect. Most of the reform movements were directed toward children in institutions, however, and were aimed at preventing a neglected child from entering a life of crime.

Probably the most significant and helpful of all reform campaigns for child protection was that launched by the American Society for the Prevention of Cruelty to Animals (ASPCA). In 1874, a church worker sought the help of the President of the ASPCA on behalf of an abused child. The case concerned a ten-year-old foster child named Mary Ellen Wilson who was the victim of child abuse. At that time there were laws which protected animals but no local, State or Federal laws to protect children. The case was presented to the court on the theory that the child was a member of the animal kingdom, and therefore entitled to the same protection which the law gave to animals.9/

7/ Thomas. Mason P. Child Abuse and Neglect. Part I: Historical Overview, Legal Matrix and Social Perspectives. North Carolina Law Review, v. 50: 305.

8/ Ibid. p. 305.

9/ New York Times, April 10, 11, 1874, and December 27, 1875.

In the aftermath of public indignation over the case, Elbridge T. Gerry, the lawyer who represented the ASCPA, founded the New York Society for the Prevention of Cruelty to Children. It was originally organized as a private group and later incorporated. Legislation was soon passed in New York and cruelty societies were authorized to file complaints for the violation of any laws relating to children, and law enforcement and court officials were required to aid the societies.

Similar societies were soon organized in other cities throughout the country and by 1922 there were 57 Societies for the Prevention of Cruelty to Children, and 307 humane societies concerned with the welfare of children. With the advent of government intervention into child welfare the number of these societies has declined.

Recent Developments

One of the main reasons for the lack of prosecution in child abuse cases has always been the difficulty in determining whether the physical injury was, in fact, a case of deliberate assault or an accident. In recent years, however, doctors in the area of pediatric radiology have been able to determine the incidence of repeated child abuse through more sophisticated developments in x-ray technology. These advances have allowed radiologists to see more clearly such things as subdural hematomas (blood clots around the brain resulting from blows to the head) and abnormal fractures. This has brought about more recognition of the widespread incidence of child abuse and public reaction has been on the rise.

State Legislation

The discovery of the bruised and weighted down body of three-year old Roxanne Felumero in the East River in 1969 set off particular furor when it was discovered that just two months prior to her death her parents had been brought before the New

York Family Court for alleged neglect and abuse, and the judge had released the child back to their custody. The inability of the courts to conclusively prove the criminal act of child abuse can lead to just this kind of tragic situation.

The problem of protecting a child from abuse is a particularly difficult one, for it involves a victim who often will not, or cannot testify against his or her attacker; it is usually committed in the privacy of the home, and even when it is reported,it is difficult to prove in the absence of eyewitnesses.

All fifty States have some form of child abuse laws. These are basically concerned with reporting laws which encourage or require the reporting of suspected child abuse (usually by doctors and other professional persons); criminal law provisions to punish those who abuse children; juvenile court acts, and State legislation to establish or authorize protective services for children.

Between 1963 and 1969, all fifty State legislatures passed some kind of child abuse reporting statute, and all but four had mandatory requirements for reporting. (See Part III-B --The Laws for Reporting Child Abuse.) It is estimated that there are thousands of cases of child abuse which remain unreported every year. The problem is difficult to solve through legislation. The reluctance of people to get involved, and the possibility of civil suits against them if they do, seems to remain a deterrent, despite the fact that all but one of the States have passed some form of immunity legislation. Part of the problem may also lie in the lack of information about the subject. The first studies which appeared in the early 1960's were often more sensational than informative. Since that time more substantive studies have been conducted.

The degree of immunity given and laws making the reporting of child abuse mandatory vary from State to State. In many States there are penal sanctions for failure to report. Most of these involve financial penalties, but there are a few States which have criminal penalties. Because of the variance of reporting laws, legislative models have recently been proposed by such groups as the United States Children's Bureau, the Council of State Governments, the American Humane Association and the American Medical Association.

Federal Legislation

The Federal Government did not get involved in child welfare until 1912, when after considerable debate, Congress passed a bill to create the United States Children's Bureau. This bill was signed into law by President Taft on April 9, 1912, and authorized the creation of a special bureau to do research and provide information about children. In 1935, with the passage of the Social Security Act, the Federal Government became more directly involved in child welfare services. The grants were to be used for "...the protection and care of homeless, dependent and neglected children and children in danger of becoming delinquent." (Now Title IV-B)

The 1962 Social Security Amendments required each State to make child welfare services available throughout the State to all children and provide coordination between current child welfare services (Title IV-B) and the social services under the Aid to Famililies With Dependent Children (IV-A) program. This latter requirement was to be accomplished by making maximum use of child welfare staff in providing consultation and services for children in families receiving public assistance. The 1962 amendment also revised the definition of "child welfare services" to specifically include reference to the prevention or remedying of child abuse.[10]

Since 1962, most of the funds for services for child protection have been spent under Title IV-A (new Title XX, effective October 1, 1975) which provides services primarily for families on welfare, with the major portion of funds under

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[10] U.S. Congress. Senate. Committee on Finance. Report on H.R. 10606 - Public Welfare Amendments of 1962. 87th Congress, 2nd Session, Washington, D.C., U.S. Govt. Print. Off., 1962: 15.

Child Welfare Services (Title VI-B) being spent on foster care. For example, of fiscal year 1972 Federal and non-Federal expenditures, it is estimated that $99.4 million was spent under Title IV-A Social Services Program for child protection services, as compared to $8.4 million for child protection services under Title IV-B.[11] Under Title IV-B Federal funding has been fixed by appropriations acts at between $46-$50 million each of the last several years, whereas under Title IV-A there is 75% Federal matching and, up until 1973, there was completely open-ended funding. (With the enactment of P.L. 92-512 a $2.5 billion limit was placed on Federal funding of Social Services.)

Services for child protection (under Title IV-A & B) end as soon as the child is removed from the home, but may be continued indirectly through foster care services for children removed from a home because of abusive treatement.

Funds have also been granted under Title V (Maternal and Child Health) for research studies on the subject of child abuse and neglect.

Thus, Federal legislative activity in the area of child abuse (with the exception of legislation for the District of Columbia) has been concentrated on financial assistance to the States for child welfare and social services and in research grants. Traditionally, the Federal government has stayed away from specific legislation regarding child abuse, considering it under the jurisdiction of the States. In the last few years, however, perhaps because of increasing awareness of the incidence of child abuse, and the resulting public outcry, a number of bills were introduced in Congress concerning mandatory reporting requirements and the creation of a National Center on Child Abuse and Neglect.

On January 31, 1974, one of these bills (S. 1191), entitled The Child Abuse Prevention and Treatment Act was enacted (P.L. 93-247). The following section provides further information on this act.

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[11] U.S. Congress. Senate. Committee on Finance. Staff Data and Materials on Social Service Regulations. 93rd Congress, 1st Session, Washington, D.C., U.S. Govt. Print. Off., 1973: Table A.

II. THE CHILD ABUSE PREVENTION AND TREATMENT ACT (P.L. 93-247)

A. Brief Description

This act provides for the following: (1) The collection and dissemination of information, including the incidence of child abuse and neglect; (2) A source of funding through grants or contracts to public and non-public agencies involved in the area of child abuse and neglect; (3) A source of funds for innovative demonstration projects which would be designed to prevent and/or treat child abuse and neglect; (4) An Advisory Board on Child Abuse and Neglect to assist the Secretary of HEW in coordinating new programs and in the development of federal standards for those programs and projects, and (5) Encouragement to the States by way of a grant for the payment of expenses involved in developing, strengthening and carrying out child abuse and neglect prevention and treatment programs.

B. Implementation of Act

Authorizations

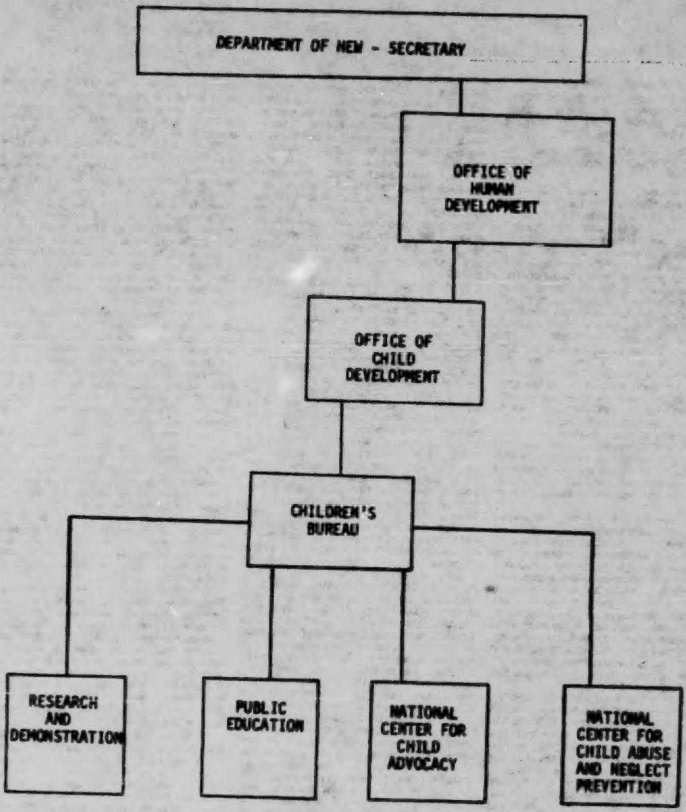
The act authorizes a total of $85 million ($15 million for fiscal year ending June 30, 1974; $20 million for fiscal year ending June 30, 1975; $25 million for fiscal year ending June 30, 1976, and for the succeeding fiscal year) for four fiscal years.

Appropriations

$4.5 million was appropriated by Congress in the 1974 Second Supplemental Appropriations Act for the purposes of child abuse prevention and treatment. This $4.5 million was obligated in 1975, and together with the $15 million appropriated by Congress in 1975, resulted in a total of $19.5 million for child abuse and neglect prevention in FY 1975. In his 1976 budget request, President Ford requested $18.9 million for the child abuse prevention program.

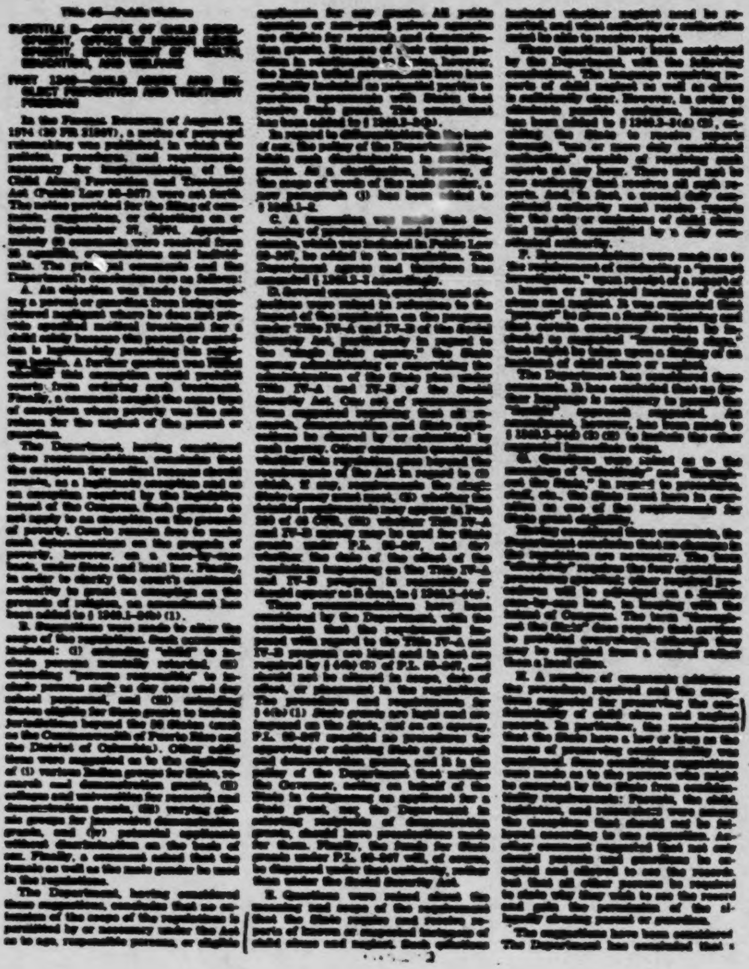
The National Center for Child Abuse and Neglect

This center is located in the Department of Health, Education, and Welfare in the Children's Bureau.


DEPARTMENT OF HEW - SECRETARY
OFFICE OF HUMAN DEVELOPMENT
OFFICE OF CHILD DEVELOPMENT
CHILDREN'S BUREAU
RESEARCH AND DEMONSTRATION
PUBLIC EDUCATION
NATIONAL CENTER FOR CHILD ADVOCACY
NATIONAL CENTER FOR CHILD ABUSE AND NEGLECT PREVENTION

C. Regulations

Final regulations issued by the Office of Child Development were printed in the Federal Register of December 19, 1974 as follows:



[illegible]

State law(s) is an allowable procedure (no procedure is stated in the law) and is keeping with the importance of confidentiality provides a stronger, more effective safeguard to the rights of children, their parents, or guardians than other methods of protection. On the other hand, to require that all persons seeking access to the records gain the permission of an allegedly abusing or neglecting parent or guardian would drastically hamper the reporting process and the use of information in the record. Finally, all of the exceptions to the confidentiality law are recognized, not required; but they all have a substantial, rational basis and would be beneficial.

I. Requests were made for clarification of some terms in regard to State grants. Among these are: (i) Does the maintenance of effort section apply to (and only to) *State* support of child abuse and neglect programs; and (ii) what is the meaning of the term "preferential treatment," to be accorded by States to parental organizations combatting child abuse and neglect?

These comments have been considered by the Department, with conclusions as follows: (i) It is the *State* support that must be maintained at the same level as in Federal Fiscal Year 1973, and an amendment to such an effect has been added to § 1340.3-3(d)(8); and (ii) preferential treatment will be judged on a case-by-case basis on the basis of State plans, procedures, and rulings.

Effective date. This part shall become effective December 18, 1974: *Provided, however,* That with respect to the requirements imposed upon the single State agency in regard to new or continued eligibility for Federal financial assistance for programs or projects related to child abuse and neglect contained under Part A or B of Title IV of the Social Security Act, the effective date shall be July 1, 1975, or the close of the next legislative session, whichever is later.

Dated: December 13, 1974.

CASPAR W. WEINBERGER,
Secretary.

Subtitle B of 45 CFR Chapter XIII is amended by adding Part 1340 as follows:

Subpart A—General Provisions

Sec.
1340.1-1 Purpose of the program.
1340.1-2 Definitions.
1340.1-3 General administrative requirements.
1340.1-4 Application for a grant.
1340.1-5 Awards.
1340.1-6 Conflict of interest.
1340.1-7 Non-allowable costs.
1340.1-8 Grant appeals.
1340.1-9 Civil rights.
1340.1-10 Non-discrimination of handicapped.
1340.1-11 Project duration.
1340.1-12 Program and project plan amendments.
1340.1-13 Protection of human subjects.
1340.1-14 Publications and copyright policy.
1340.1-15 Reports.

Subpart B—Demonstration, Technical Assistance, and Other Activities

Sec.
1340.2-1 Demonstration.
1340.2-2 Technical assistance.
1340.2-3 Training materials and Training.
1340.2-4 Research.
1340.2-5 Confidential information.

Subpart C—[illegible]

1340.3-1 Purpose and eligible applicants.
1340.3-2 Maintenance of expenditures.
1340.3-3 Qualification for assistance.
1340.3-4 Approval of compliance statements and plan amendments.
1340.3-5 Approval of applications, plan amendments, and funds.
1340.3-6 Funds available.
1340.3-7 Allocation of funds available.
1340.3-8 Reallocation of funds available.

AUTHORITY: Sec. 2, 88 Stat. 5 (Sec. 2, Pub. L. 93-247); Sec. 4(d), 88 Stat. 7 (Sec. 4(d), Pub. L. 93-247).

Subpart A—General

§ 1340.1-1 Purpose of the program.

(a) The basic purpose of this program is to assist States and localities, and nonprofit private organizations to carry out their responsibilities for the protection of children and for the amelioration of their environment, particularly as an integral part of a family unit whose adult member(s) need help in coping with emotional or environmental stresses.

(b) The main thrust of this program effort is to assist State, local, and voluntary agencies and organizations to strengthen their capacities to develop programs that will:

(1) Prevent child abuse and neglect;

(2) Identify abused and neglected children; and

(3) Provide necessary ameliorative services to them and their families.

(c) In order to achieve this purpose, the National Center on Child Abuse and Neglect will:

(1) Develop, gather, analyze, and disseminate information on child abuse and neglect research, public and private programs, training materials, and the national incidence of child abuse and neglect;

(2) Provide technical assistance to public agencies and nonprofit private organizations to assist them in their activities relating to the prevention, identification, and treatment of child abuse and neglect;

(3) Conduct research in order to develop new techniques in identifying, preventing, and treating child abuse and neglect; and

(4) Make grants and enter into contracts for demonstrations and program models designed to develop and establish improved training programs, more effective service delivery vehicles, and for other innovative programs and projects showing promise of successfully preventing or treating child abuse and neglect.

(d) In addition to directly assist and encourage States to improve their capacity to identify, prevent, and treat child abuse and neglect, the Secretary will:

(1) Provide Federal financial assistance under the Act to States meeting the requirements therefore; such assistance is designed to enable States to develop, strengthen, and carry out activities related to child abuse and neglect and

(2) Require the single State agencies to meet specified requirements in order to receive assistance for activities related to child abuse and neglect contained under Part A or B of Title IV of the Social Security Act.

§ 1340.1-2 Definitions.

For purposes of this part—

(a) "Act" means the Child Abuse Prevention and Treatment Act, 88 Stat. 4 (Pub. L. 93-247), unless otherwise specified.

(b) "Child abuse and neglect" means harm or threatened harm to a child's health or welfare by a person responsible for the child's health or welfare.

(1) "Harm or threatened harm to a child's health or welfare" can occur through: Non-accidental physical or mental injury; sexual abuse, as defined by State law; or negligent treatment or maltreatment, including the failure to provide adequate food, clothing, or shelter: *Provided, However,* that a parent or guardian legitimately practicing his religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian; *However,* such an exception shall not preclude a court from ordering that medical services be provided to the child, where his health requires it.

(2) "Child" means a person under the age of eighteen.

(3) "A person responsible for a child's health or welfare" includes the child's parent, guardian, or other person responsible for the child's health or welfare, whether in the same home as the child, a relative's home, a foster care home, or a residential institution.

(c) "Director" means the Director of the Office of Child Development.

(d) (1) "Facility" means a building or portion thereof used to house programs or services designed to treat or prevent child abuse and neglect such as alternative homes; emergency shelters; nurseries or treatment rooms or wards; central reporting registries; hot line services; diagnostic treatment and training centers; hospital emergency rooms and neighborhood health centers; and other services or programs established to deal with the prevention and treatment of child abuse and neglect.

(2) "Repair or minor remodeling or alteration of an existing facility" means the physical modification of the facility, the cost of which must be reasonable in relation to the total proposed cost of the program or project and is consistent with the provisions of Chapter 1-44 of the Grants Administration Manual of the Department of Health, Education, and Welfare.

(e) "Non-profit private organization" means a corporation or association, the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1954.

(f) "Project period" means the total period of time for which a project is approved for support with Federal funds.

(g) "Secretary" means the Secretary of the Department of Health, Education, and Welfare.

(h) "State" means one of the fifty States.

(i) "The single State agency" means the State agency administering or supervising the administration of the State plan under title IV–A and IV–B of the Social Security Act.

(j) As used in this part, words importing the masculine gender may be applied to female persons or organizations.

§ 1340.1–3 General administrative requirements.

(a) The provisions of Part 74 of this title shall apply to all grants made under this part to units of State and local government, as defined in Part 74 of this title, and the following subparts of Part 74 shall apply to grants to nonprofit private organizations:

Subpart:	*Subject*
A	General.
B	Cash depositories.
C	Bonding and insurance.
D	Retention and custodial requirements for records.
F	Grant-related income.
K	Grant payment requirements.
L	Budget revision procedures.
M	Grant closeout, suspension, and termination.
O	Property.
Q	Cost principles.

(b) Any contract under this part shall be entered into in accordance with and shall conform to all applicable laws, regulations, and other published Departmental policy.

§ 1340.1–4 Application for a grant.

(a) An application for a grant under this part shall be submitted by such time and in such form and manner as the Director may prescribe. The application shall contain a budget and narrative plan of the manner in which the applicant intends to conduct the project and carry out the applicable requirements of this part.

(b) The application must be signed by an individual authorized to act for the applicant and to assume for the applicant the obligations imposed by the statute, the applicable regulations of this part, and any additional conditions of the grant.

§ 1340.1–5 Awards.

All grant awards and contract awards for programs or projects under the Act shall be in writing and shall constitute the encumbrance of the Federal funds awarded. An award shall specify the project period.

§ 1340.1–6 Conflict of interest.

Employees or individuals participating in a program or project under the Act shall not use their positions for a purpose that is, or gives the appearance of being motivated by a desire for private gain for themselves, or others, particularly those with whom they have family, business or other ties.

§ 1340.1–7 Non-allowable costs.

(a) Federal financial assistance is not available under the Act for the construction of facilities.

(b) No Federal financial assistance may be furnished under the Act for the cost of activities for which payment is made under another part of this chapter or under other authority for the same purpose.

§ 1340.1–8 Grant appeals.

When a post-award dispute arises in the administration of grants under the Act following certain determinations adverse to a grantee, the grantee may apply for a review of such determination in accordance with the provisions of Subtitle A, Part 16, of this title.

§ 1340.1–9 Civil rights.

Attention is called to the requirements of title VI of the Civil Rights Act of 1964 (78 Stat. 252 (42 U.S.C. 2000d et seq.)) and in particular section 601 of such act, which provides that no person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. A regulation implementing such title VI, which applies to grants and contracts made under this part, has been issued by the Secretary of Health, Education, and Welfare with the approval of the President (45 CFR Part 80).

§ 1340.1–10 Non-discrimination of handicapped.

No otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in any program, project, or activity assisted under the Act. No otherwise qualified individual shall be denied employment in any program, project, or activity assisted under this part solely because of a physical or mental disability (Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794)).

§ 1340.1–11 Project duration.

Programs and projects may be approved for a period not to exceed five years. Program and project budgets must be submitted and will be reviewed and approved annually.

§ 1340.1–12 Program and project plan amendments.

(a) The grantee shall submit an amendment describing any material change in the plan of his program or project proposed to be made during the project period. Proposed program or project plan amendments shall be submitted in writing for appropriate review prior to consideration by the Director.

(b) Proposed program and project plan amendments may be initiated by the Director if, on the basis of reports, it appears that Federal funds are being used for purposes beyond the scope of the approved project application.

§ 1340.1–13 Protection of human subjects.

The provisions of Part 46 of Subtitle A of this part, the Protection of Human Subjects, shall apply to all grants and contracts awarded under the Act supporting research, development, and related activities in which human subjects at risk, as defined in 45 CFR Subtitle A, § 46.3(b), are involved.

§ 1340.1–14 Publications and copyright policy.

(a) The results of any activity supported under this part may be published without prior review by the Department: *Provided*, That such publication's preface shall acknowledge the Federal assistance received and stating that interpretations of data do not necessarily represent interpretations of the Department and *Provided, further*, that 25 copies of such publications are furnished to the Department.

(b) Where a project activity leads to the publication of a book or other copyrighted material, the author is free to copyright the work, but the Department reserves royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to use, all copyrightable or copyrighted material resulting from the grant-supported activity. Any such publication shall contain a notice of such license.

§ 1340.1–15 Reports.

Reports shall be made to the Director in such form and containing such information as the Director may find necessary to enable the Director to perform his functions under this part.

Subpart B—Demonstration, Technical Assistance, and Other Activities

§ 1340.2–1 Demonstration.

(a) *Eligible applicants or contractors.* The Director will make grants to or enter into contracts with public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects.

(b) *Nature of demonstration programs and projects.* (1) Such demonstrations may include, but are not limited to pilot or experimental efforts to provide additional and more effective ways of preventing, identifying or treating child abuse and neglect than are currently available; testing the feasibility of providing child abuse and neglect services in new settings or under new conditions; innovative programs and methods of providing preventive and treatment services in urban and in rural areas; methods of coordinating most effectively the variety of disciplines and agencies involved in child abuse and neglect; the establishment and maintenance of facilities, such as central registers, satellite centers, attention homes, emergency shelters, hospital emergency rooms, neighborhood health centers, and "hot lines"; provision of consultation by teams to small communities; programs for the prevention and treatment of child abuse related to drug abuse; and, parent self-help projects and programs.

(2) All such demonstrations shall be evaluated, either as a part of the program or project or through a separate contractual effort. All demonstration programs should include provisions for continuing the program within the agency or organization or under other auspices upon the termination of funding under the Act. These provisions should be reasonable and firm commitments rather than hopeful expectations.

(c) *Manner of solicitation.* (1) Grant applications will be solicited through Program Announcements specifying the project goals and objectives for which applications are being solicited, the criteria by which they will be judged, the amount of funds available for such grants, and the deadline for receipt of applications.

(2) Contracts will be awarded in accordance with the procurement regulations of the Department of Health, Education, and Welfare (41 CFR Subtitle A, Part 3).

(d) *For purposes of appropriation.* Not less than 50 per centum of the funds appropriated under the Act for any fiscal year shall be used for carrying out the provisions of subsection 4(a) of the Act.

(e) *Special criteria for achieving equitable distribution.* (1) The formula prescribed in § 1340.3-7, which includes for each State a minimum amount and an additional amount based on the number of children under the age of eighteen, is designed to achieve equitable distribution of assistance among the States.

(2) In the selection of applications submitted under this subpart which are judged to be of approximately equal merit, the Director will take into account the extent to which the selection of one applicant as against the other would achieve equitable distribution of assistance among geographic areas of the Nation and among rural and urban areas.

§ 1340.2-2 Technical assistance.

Technical assistance authorized in subsection 2(b)(4) of the Act will be furnished by the National Center on Child Abuse and Neglect, directly or by contract, to public agencies and nonprofit private organizations to assist them in planning, improving, developing and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect.

§ 1340.2-3 Training materials and Training.

The National Center on Child Abuse and Neglect, directly or through contracts, will develop, compile and publish training materials and conduct training for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect.

§ 1340.2-4 Research.

The National Center on Child Abuse and Neglect will conduct research into the causes of child abuse and neglect and into the prevention, identification, and treatment thereof. Such research will include a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

§ 1340.2-5 Confidential information.

(a) All information, including lists of names, addresses, photographs and records of evaluation, obtained as to personal facts about individuals served by any demonstration, research, training or technical assistance project or program assisted under the Act shall be held to be confidential and may not be disclosed except as provided in paragraph (b).

(b) The use of such information and records shall be limited to purposes directly connected with the administration of the program or project, including evaluations thereof conducted under contract from the Department of Health, Education, and Welfare, and such information may not be disclosed, directly or indirectly, other than for such a purpose thereof or pursuant to the requirements of § 1340.3-3(d)(8), unless the written consent of the agency providing the information and the individual to whom the information applies or his responsible relative has been obtained. No report or other documentation of a program or project to be disclosed outside the program or project may contain information that could serve to identify any person without his written consent or that of his representative.

Subpart C—Child Abuse and Neglect Grants to States Under the Act and Under Title IV of the Social Security Act

§ 1340.3-1 Purpose and eligible applicants.

(a) States that qualify under § 1340.3-3, may receive grants to initiate or continue the support of programs or projects of the State or one of its political subdivisions which can be expected to assist the State in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs. The Act also requires that the single State agency comply with certain requirements in order to begin or continue the receipt of funds for programs or projects related to child abuse and neglect, funded under Part A or B of Title IV of the Social Security Act.

(b) This subpart describes the procedures States must follow to establish their compliance and to apply for funds provided under section 4(b)(1) of the Act (Pub. L. 93-247). The process the single State agency must follow to establish compliance under the Act (and under the Social Security Act) is described in 45 CFR Part 220.

§ 1340.3-2 Establishment of compliance.

(a)(1) In order to be eligible for Federal financial assistance for programs or projects related to child abuse and neglect funded under section 4(b)(1) of this Act, a State shall provide, in such form and with such documentation as the Secretary may require, a statement that the State meets the requirements of the Act and of this part, signed by the Governor. All legal opinions shall be certified by the Attorney General of the State.

(2) In order to be eligible for Federal financial assistance for programs or projects related to child abuse and neglect funded under Part A or B of Title IV of the Social Security Act, the single State agency shall provide, in such form and with such documentation as the Secretary may require, a statement that it meets the requirements of the Act (Pub. L. 93-247) and the Social Security Act, in accordance with regulations published in 45 CFR Part 220.

(3) For programs or projects funded under section 4(b)(1) of the Act, the requirements are set forth in § 1340.3-3(d)(1)–(10). For programs or projects funded under Part A or B of Title IV of the Social Security Act, the requirements are set forth in 45 CFR 220.

(b) Whichever State office, agency, or organization is designated by the Governor, may apply for financial assistance under section 4(b)(1) for the payment of reasonable and necessary expenses in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs. Such State office, agency, or organization need not be limited in its mandate or activities to child abuse and neglect. Such State office, agency, or organization designated by the Governor may enter into purchase agreements with other offices, agencies, or organizations (including Indian Tribal or organizations) to conduct activities under the grant. The application for such funds shall include a description of the activities presently conducted by the State and its political subdivisions in relation to prevention and treating child abuse and neglect, the activities to be assisted under the grant, a statement of how the proposed activities are expected to develop, strengthen or carry out child abuse prevention and treatment programs, together with a budget in the form and detail and in accordance with the procedures prescribed by the Secretary, and such additional information in such form and with such documentation as the Secretary may require.

§ 1340.3-3 Qualification for assistance.

(a) The Act enumerates ten elements of a comprehensive system to prevent and treat child abuse and neglect which a State must have in order to qualify for assistance under section 4(b)(1). The enactment of identical laws and procedures in the States is not necessary. Rather, as its purpose, the Act seeks to insure that all States receiving assistance under this subsection (in meeting the ten requirements) must provide what may be grouped into four fundamental child protection capabilities: (1) Detection through third party reporting of children in danger, including mandatory and permissive reporting of suspected child abuse and neglect; (2) child protective services to provide non-criminal investigations for the verification of reports, to provide immediate protection of children through such means as protective custody, and to provide rehabilitative and ameliorative services; (3) juvenile or family court action to remove a child or to impose treatment services; and (4) law enforcement investigations and criminal court prosecution, when appropriate.

(b) Similarly, it is not necessary for States to adopt language for the definition of "child abuse and neglect" identical to that used in the Act. A State definition which is the same in substance as the one set forth in this part will be sufficient. In addition, nothing in this part is intended to prevent a State from further elaborating on the definition or from providing additional grounds to consider a child abused or neglected. This part takes this approach in recognition of the need to allow and encourage flexibility and innovation in light of the diverse local conditions found from State to State and community to community.

(c) Finally, in order to facilitate compliance, this part makes a distinction between requirements that can be satisfied by a specific State law and those that can be satisfied by a legally authorized and legally binding administrative procedure, if certified by the State's Attorney General.

(d) In order for a State to qualify for assistance under section 4(b)(2) of the Act, the State shall satisfy each of the following ten requirements:

(1) The State must have in effect a child abuse and neglect law which includes provisions for immunity for all persons reporting, whether mandated by law or not, instances of known or reasonably suspected child abuse and neglect, from civil or criminal penalties under any State or local law, arising out of such reporting. In the absence of a specific statutory provision in an existing child abuse and neglect reporting law, this requirement may be satisfied, but only until July 1, 1975, or the close of the next session of the State legislature, whichever is later, by a legal opinion of the State's Attorney General holding that such immunity exists under State law.

(2)(i) The State must provide for the reporting of known or suspected instances of child abuse and neglect. This requirement shall be deemed satisfied if a State requires specified persons by law, and has a law or administrative procedure which requires, allows, or encourages all other citizens, to report known or suspected instances of child abuse and neglect to one or more properly constituted authorities with the power and responsibility to perform an investigation and take necessary ameliorative and protective steps as required in paragraph (3). A properly constituted authority may include the police, the juvenile court or any agency thereof, or a legally mandated, public or private child protective agency: *Provided, however*, That a properly constituted authority must be an agency other than the agency, institution or facility involved in the acts or omissions, if the report of child abuse and neglect involves the acts or omissions of a public or private agency or other institution or facility.

(ii) In the absence of a specific statute, the requirements of this subdivision may be satisfied by an opinion of the State Attorney General holding that the State administrative procedures in this regard are legally binding.

(3)(i) A State must provide that upon the receipt of a report of known or suspected instances of child abuse or neglect an appropriate investigation by a properly constituted authority shall be initiated promptly to substantiate the accuracy of the report. Such investigation may include consultation with central registers, field visits, consultation with other agencies, medical examinations, and psychological and social evaluations.

(ii) The State must provide further that, upon a finding of abuse or neglect, immediate steps, as required by law and/or administrative procedure, shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect. Such steps may include [illegible] emergency caretaker service, homemaker service, emergency shelter care, emergency medical services, and, if appropriate, criminal court or juvenile court action, in order to protect the child and help strengthen the family, help the [illegible], and if necessary, remove the child from a dangerous situation.

(4) The State must demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State has [illegible]

(5) The State must provide for methods to preserve the confidentiality of all records concerning reports of child abuse and neglect in order to protect the rights of the child, his parents or guardians. [illegible]

[illegible]

(6) The State must provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and all appropriate State agencies providing human services in relation to preventing, identifying and treating child abuse and neglect. Such cooperation may include joint consultation and services, joint planning, joint case management, joint public education and information services, utilization of each other's facilities, and joint staff and other training.

(7) The State must provide that in every case involving an abused or ne-

glected child which results in a judicial proceeding, a guardian ad litem shall be appointed to represent the child in such proceedings. The requirement of this clause may be satisfied by a State law or by a legal opinion of the State's Attorney General holding that such appointments can be made, and by a statement from the Governor that such appointments are made, in all cases. Such guardian ad litem need not be an attorney; however, such representative may be an attorney charged with the prosecution in a judicial proceeding of the evidence alleged to amount to the abuse and neglect, so long as his legal responsibility includes representing the rights, interests, welfare, and well-being of the child; where such appointments are made, the legal opinion of the State Attorney General must specify that such attorney has said legal responsibility.

(8) The State must provide that the aggregate of State support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during Federal fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects.

(9) The State must provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and the prevention and treatment methods available to combat instances of child abuse and neglect; and

(10) To the extent feasible, the State must insure that parental organizations combating child abuse and neglect, as recognized by the State, receive preferential treatment.

§ 1340.3-4 Approval of compliance statements and plan amendments.

(a) The Secretary shall approve a compliance statement submitted under this subpart if he finds that it meets the requirements of this subpart and of the Act.

(b) If a State does not appear to meet the requirements of this subpart, the State will be provided reasonable opportunity to qualify before final action on the application or continued extension of funds is taken by the Secretary.

(c) The requirement that a single State agency must comply with section 4(b)(2) of the Act and 45 CFR Part 220 in order to continue receiving funds for programs or projects related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act shall take effect on July 1, 1975, or the close of the State's next legislative session, whichever is later.

§ 1340.3-5 Approval of applications, plan amendments, and funds.

(a) The Secretary shall approve an application for funds under section 4(b)(1) of the Act if he finds: (1) That the State applying for such funds qualifies for such funds under section 4(b)(2) of the Act, (2) that the funds are intended to be used to develop, strengthen, or carry out child abuse or neglect prevention or treatment programs, (3) that the State is otherwise in compliance with these regulations, and (4) that the funds requested are within the State's allocation as determined pursuant to § 1340.3-7.

(b) The Secretary shall approve the initial or continued use of funds for the single State agency's programs or projects related to child abuse and neglect assisted under Part A or B of Title IV of the Social Security Act if he finds that the single State agency qualifies for such funds under the Act (Pub. L. 93-247) and under the Social Security Act, in accordance with the regulations published in 45 CFR Part 220.

§ 1340.3-6 Funds available.

Not less than 5 per centum and not more than 20 per centum of the sums appropriated under the Act shall be used by the Secretary for making grants to the States under subsection 4(b)(1) of the Act.

§ 1340.3-7 Allocation of funds available.

(a) Funds available for grants to States for a fiscal year under section 4(b)(1) of the Act shall be allocated among the States on the basis of the following criteria:

(1) An amount of $30,000, or such other amount as the Secretary may determine, for a fiscal year, plus,

(2) An additional amount bearing the same ratio to the total amount made available for this purpose (after providing for the minimum amounts in paragraph (1)) as the number of children under the age of eighteen in each State bears to the total number of children under eighteen in all the States. The number of children under the age of eighteen to be used in this allocation shall be the number as determined by official estimates furnished to the Secretary by the Department of Commerce by October 1 of the fiscal year for which Federal grant funds are appropriated.

(b) The Director will announce the allocations available to the States under section 4(b)(1) of the Act and this subpart.

§ 1340.3-8 Reallocation of funds available.

If a State has not qualified for assistance under section 4(b)(1) of the Act prior to the date designated by the Secretary in each fiscal year, the amount previously allocated to that State under § 1340.3-7 shall be used by the National Center on Child Abuse and Neglect for such purposes under the Act as the Secretary shall determine.

[FR Doc.74-[illegible] Filed 12-18-74;8:45 am]

D. Text

Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act". Child Abuse Prevention and Treatment Act. 88 STAT. 4

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center"). 88 STAT. 5 Establishment.

(b) The Secretary, through the Center, shall—

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect; Annual research summary.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect; Information clearinghouse.

(3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity. Study.

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be— Grants and contracts.

(1) for the development and establishment of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect; 88 STAT. 6

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel which are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Not less than 50 per centum of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.

(b) (1) Of the sums appropriated under this Act for any fiscal year, not less than 5 per centum and not more than 20 per centum may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs. Grants to States.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting;

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians; 88 STAT. 7

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and appropriate State agencies providing human services;

(G) provide that in every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;

(H) provide that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects;

(I) provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect; and

(J) to the extent feasible, insure that parental organizations combating child abuse and neglect receive preferential treatment.

(3) Programs or projects related to child abuse and neglect assisted under part A or B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), and (F) of paragraph (2). 49 Stat. 627; 81 Stat. 911. 42 USC 601, 620.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purposes of this Act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, and $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal year.

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the date of enactment of this Act, appoint an Advisory Board on Child Abuse and Neglect (hereinafter referred to as the "Advisory Board"), which shall be composed of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, Membership.

Functions.

the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.

Report to President and Congress.

(b) The Advisory Board shall prepare and submit, within eighteen months after the date of enactment of this Act, to the President and to the Congress a report on the programs assisted under this Act and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or $1,000,000, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 93-685 (Comm. on Education and Labor).
SENATE REPORT No. 93-308 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
    July 14, considered and passed Senate.
    Dec. 3, considered and passed House, amended.
    Dec. 20, Senate agreed to House amendments with amendments.
    Dec. 21, House concurred in Senate amendments.

III. SELECTION OF RECENT ARTICLES*

A. General Information

1. D.H.E.W., Child Abuse and Neglect. A Report on the Status of Research (Publ. No. OHD 74-20)
2. Child Abuse: Pathological Syndrome of Family Interaction. American Journal of Psychiatry. August 1974.
3. The Child Sex Victim: Social, Psychological and Legal Perspectives. Child Welfare. March 1973.

B. Child Abuse and the Law

1. Child Abuse Legislation in the 1970's. American Humane Association. Revised 1974.
2. Child Abuse: Attempts to Solve the Problem by Reporting Laws. Women Lawyer's Journal. Spring 1974.

C. Treatment

1. Treatment for Child Abusers. Social Work. May 1974.
2. Child Abuse and Neglect Concerns SRS Multi-Efforts. Social and Rehabilitation Record. June 1974.
3. Child Abuse: A Killer Teachers Can Help Control. Phi Delta Kappan, March 1975.
4. Child Abuse. Hospitals Combat Neglected Health Crisis. Hospitals, J.A.H.A., Sept. 1. 1974.

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A. General Information

CHILD ABUSE AND NEGLECT

A Report on the Status of the Research

by
Maure Hurt, Jr., Ph.D.
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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development/Office of Child Development

DHEW Publication No. (OHD) 74—20

CHAPTER II

Characteristics of Abuse and Neglect

Deliberate abuse of a child by its parents is regarded by many as monstrous and unnatural. In fact a number of researchers (Silver *et al.*, 1969, and Caffey, 1972b) have found that disbelief in even the possibility of child abuse has ruled out that diagnosis.

The question remains, how can parents do these things? A major part of the research effort in the field has been focused on understanding what happens when a child is abused or neglected.

Dr. Ray Helfer (Kempe & Helfer, 1972) has identified three major contributing variables in an incident of abuse:

PARENT + CHILD + SITUATION = ABUSE

The same variables are present in neglect. Helfer's formulation points out that each incident contains all three elements, and most researchers have been aware that no single element provides a sufficient explanation. Still, research studies tend to focus on one of the three rather than all the elements at once. This chapter reports research on the characteristics of parents who abuse or neglect their children; of the children who are abused or neglected; of the situations in which abuse and neglect typically occur; and of the long- and short-term effects of abuse on both parents and children.

Characteristics of Parents

Many researchers have attempted to analyze and describe the characteristics of parents who abuse their children. One of the earliest reports is from Ambroise Tardieu (cited in Silverman, 1972). Writing in the 1860's in France, Tardieu described the syndrome which Kempe *et al.* (1962) now call the Battered Child Syndrome, and which Caffey calls the Parent-Infant Traumatic Stress Syndrome (PITS 1972b). Tardieu described some of the behavioral characteristics of the abusing parent, and also identified environmental conditions that may be associated with abuse, including unemployment and social isolation. Many of his results are wholly consistent with modern research findings.

Several of the present day research efforts have attempted to go beyond description to the formulation of predictive models based on the characteristics of abusing parents. The models would be used to determine when the children could safely be left with their parents, when they should be separated from the parents, and when the parents, with proper treatment and adequate social services, could safely be reunited with their children. Delsordo (1963), Zalba (1967), and Boisvert (1972) have made contributions to such a predictive model.

Delsordo devised five categories for the classification of abusing parents:

Category	Intervention
1. Mentally ill	Termination of rights
2. Overflow abuse	Termination of rights
3. Battered child	Termination of rights
4. Disciplinary abuse	Agency intervenes with service
5. Misplaced abuse	Agency intervenes with service

1. Abusers found to be mentally ill are unfit parents who need hospitalization and psychiatric treatment. Termination of parental rights may be indicated in these cases.
2. Parents exhibiting overflow abuse are unable to cope with ". . . their own frustrations, irresponsibility, and lack of belief in themselves and anything else." They compensate by abusing anyone or anything, especially a child, who becomes a burden for them. They lack the mental and physical energy necessary to establish a healthy family environment. Termination of parental rights is suggested.
3. The parents of battered children regard the child as a competitor or a special burden and feel that he must be made to suffer or even be destroyed. These parents frequently project their own undesirable traits onto the child. They are typically dependent personalities. Delsordo believes that since they can seldom be rehabilitated, their parental rights should be terminated.
4. Parents who practice disciplinary abuse rely on stringent physical punishment to "correct" the child's real or imagined transgressions. These faults are often beyond the child's control and the punishment may be extreme—much more severe than the ordinary spanking—and may result in damage to internal organs or brain damage in infants. Delsordo feels that most of these parents can be treated successfully through intervention. Duncan (1973) believes that essentially the same type of abuse can occur in school districts which permit corporal punishment.
5. Misplaced abuse is the result of displaced aggression. For example, a woman who is beaten by her husband may abuse her child rather than show aggression toward the husband. Delsordo believes that these parents can be helped through counseling and effective social work.

The predictive value of Delsordo's categories has not been thoroughly established, but the categories do seem to be consistent with the personality characteristics and motivational factors discovered by other investigators in more empirical studies. Boisvert (1972) analyzed a sample of 20 abuse cases and found that Delsordo's categories served to describe them with only slight modification.

A number of other investigators, using data from case records or personal interviews, have developed lists of personality characteristics of parents who abuse or neglect their children. A study by Holter and Friedman (1968b) found that parents of abused children are typically immature, dependent, impulsive, rigid, self-centered, and rejecting.

Gregg and Elmer (1969) studied and compared two groups of parents—one whose infants had been injured accidentally, and another whose children had been abused. The study showed that parents in the abusing group came from lower socioeconomic levels than those in the "accident" group. Abusive parents also had significantly less knowledge of developmental skills of infants; they had noticeably lower ability to provide medical and health care for their children, both in sickness and in health; and the level of environmental stress in their homes was higher.

Bennie and Sclare (1969) depict the abusive parent as one with personality inadequacies and impulsive behavior. The parent becomes sadistic in displacing aggression which results from domestic and marital relationships. The family environment typically has a high level of stress. Feinstein *et al.* (1964) note the special case of the mother who is abused by the father and in turn abuses her child, but only if the child is a male.

Various investigators, including DeLissovoy (1973), Bullard *et al.* (1967), and Evans (1970), report that a common characteristic of abusive or neglectful parents is the lack of "mothering skills." Some parents drastically overestimate the physical and mental development of their children and demand behavior well beyond the children's capabilities. For example, toilet training is sometimes attempted as early as six weeks of age. When the child is unable to perform as expected, the frustrated parent may abuse the child. This type of punishment relates to Delsordo's category of "disciplinary abuse."

Klaus (1972) and Prescott (personal communication, 1973) note that an inadequate "mother-infant bond," which may be traced to the routine hospital procedures designed to cope with prematurity, may be a factor in abuse and neglect. Although the immediate postnatal period is critical for forming emotional attachments, premature babies are placed in incubators isolated from human contact. Their mothers are not permitted to hold them, fondle them, or come into close physical or visual contact. This separation of mother and child may contribute to later abuse or neglect.

It is a common finding that alcoholism is an associated factor in a substantial percentage of abuse and neglect cases. Swanson *et al.* (1971) comment on the special role of alcohol in some Indian cultures which "do not include an understanding that alcohol is a drug whose use without restraint is ruinous." They found that alcohol was used as a food substitute, a sedative, a medicine, and an intoxicant for children, and discovered an abnormally high percentage of alcoholic minors.

Among current research efforts, two programs of major interest are those of Schneider, Pollack, and Helfer, and a second by Newberger.

Schneider, Helfer and Pollack (in Kempe and Helfer, 1972) have completed two of the three phases of their project. In phase one, a group of 30 known abusive parents was compared with a control group of non-abusers. Both groups completed a questionnaire, the answers to which were evaluated by semantic differential methodology, using a 7-point Likert-scale. Cluster analysis revealed differences between the two groups in four crucial areas. The abusive parents, in contrast to the control group, had (1) high expectations of loneliness and isolation; (2) intense feelings of expectation about their children's behavior and levels of performance; (3) poor quality in relationships with their own parents and spouses; and (4) intense feelings of anxiety about their children's behavior.

In the second phase, the procedure was refined by replacing the original control group with individuals matched with the abusive parents for age, education, socioeconomic status, number of children in the family, and presence of a child the same age as the abused child. A second cluster analysis revealed that when the two groups were more closely matched, approximately the same cluster pattern emerged, but the clusters did not differentiate as sharply.

The authors indicate that their study seems to be revealing "abuser" and "non-abuser" personality categories. This finding may lend support to some of the categorization models already described, and supports the hypothesis that abusive behavior does not necessarily have a single motivational cause.

The project's third phase, now under way, uses a refined instrument and a larger sample group. Data have been collected but the analysis is not yet complete. The subjects are 500 new mothers who have been categorized by the type of medical care they received when their children were born: private, obstetric service in a public hospital; pediatric service; and care at a university medical center. Helfer (personal communication, 1974) indicates that preliminary data from about half the sample tend to support the personality profile clusters from the first two phases. Abusive parents have not been included in this sample intentionally, but mothers whose scores tentatively indicate that they might become abusive or neglectful will be followed up to determine how well the instrument predicts their behavior. These follow-up studies will form a basis for further refinement.

The investigators say that they would like to specify the cut-off scores between normal and high-risk parents more exactly than is now possible. Their eventual goal is to have no "false negatives" and only four percent "false positives"——that is, to have *all* known abusers identified by scores in the "high risk" range, with no false identification as non-abusers; and to have no more than four percent of the non-abusers falsely identified as high risks for abusive behavior. The authors plan to develop their instrument for self-administration and believe that eventually it will save professional time, protect young children, and identify those families which need special care.

Helfer, at Michigan State University, and Kempe and others, at the University of Colorado, are attempting to cross-validate the predictive instrument by videotaping mother-infant interactions and having experienced professionals evaluate the quality of the interaction. Results to date are extremely tentative, but seem to cross-validate.

Drs. Janeway and Newberger (Newberger, personal communication, 1974) are conducting a broad epidemiological study. Approximately 600 cases of children who have been treated for conditions such as failure to thrive, abuse and neglect, pica, ingestions, or accidents on either an in-patient or out-patient basis will be included. These cases will be comparéd with a control group matched for age, ethnic group, and socioeconomic status. The goal of the study is to refine the current state of knowledge about causal conditions within the environment with regard to particular children, and families and the "social illnesses" already mentioned. Concurrent with this study, the investigators are trying out a family advocacy technique and a parent education approach as methods of helping the abused child. The clinical program of the Boston Children's Hospital is involved in a major part of this effort. At a later date a related study with the same types of children will be conducted. This study will include home observations and interviews which may provide greater insights into differences between groups.

Newberger is also working on a retrospective cohort using data already available from the National Institute of Neurological Diseases and Stroke Perinatal Study. The data has medical and demographic information on approximately 1,500 children born in 1964 in a local Boston hospital. Newberger feels that accidents during the first year after birth may indicate parental problems. Children meeting this criterion will be compared with a control group to see if there are any significant differences in patterns emerging from a factor analysis of the data.

Characteristics of Children

The study by Janeway and Newberger, focusing on possible patterns in the characteristics of both parents and children, is one of the few investigations to date which attempts to determine the role of the child to abuse and neglect. Several researchers, however, have found indications that the child's history, characteristics, and behavior may contribute to the child being abused.

Stern (1973), for example, reports that prematurity is a factor in the infant's level of risk. Other investigators comment that its small size and early stage of physical development may make the premature infant more susceptible to long-term or permanent injuries than a normal term infant. (The relatively weak "mother-infant bond," that Klaus (1972) and Klein and Stern (1971) found associated with prematurity, would tend to contribute to the chances of injury.)

Several investigators offer insights into the possible role of the child's behavior in precipitating abuse or neglect.

Terr (1970), after a six-year follow-up of 10 cases of abuse, reported that a number of the children had developed behavior problems. Several children, including one only three years old, practiced retaliation against the abusing parent. One child refused to eat in the house, but ate garbage outside the home or begged for food. Some children violated taboos about defecation. Others broke or damaged the parent's possessions or told elaborate lies to outsiders about atrocities within the family. Terr notes that "retaliatory behaviors appeared to be hostile counter-attacks to the angry parent. They are not simply teasings or provocations of the parent, but rather the child's indulgence in full-scale battle." There can be little doubt that such behavior would contribute to further incidents of abuse.

Caffey (1972b) believes that five to ten percent of the infants in the general population may be classified as provocative and indicates that their role in the Parent-Infant Traumatic Stress Syndrome is not well understood. "It is clear that the extra stress of living with and caring for these overactive, demanding, defiant, and exhaustive infants may well paralyze the overburdened mother's self-control temporarily and release violent impulses to rid herself of him."

Gregg and Elmer (1969) tested the hypothesis that behavior typical of a particular developmental phase might be especially provocative of abuse. They studied both bonafide accidents and alleged accidents which were, in fact, abuse. They found that the number of bonafide accidents was related to particular developmental stages, but that the incidents of abuse were not concentrated at any special developmental phase.

Characteristics of the Situation

Several studies have begun to reveal a relation between the situation of the family—its social, economic, and psychological environment—and incidents of abuse or neglect.

Sattin and Miller (1971) compared abusers and nonabusers in a military community. They acknowledge the possibility of certain biasing factors which were not investigated, such as income level and social class, but indicate that abuse was more common in those residential areas where greater poverty, higher crime rates, lower quality housing, and transient populations resulted in a higher level of environmental stress.

Giovannoni and Billingsley (1970) made a study of the care provided by a sample of low income mothers, assigned by social case workers to one of three groups: adequate, potentially neglecting, and neglecting. The study indicated that the principal differentiating factors were the degree of isolation, the level of environmental stress, and the amount of support and resources available to the workers.

Helfer (in Kempe and Helfer, 1972) contributes insight into the relations between the parents, children, and the situation. The three necessary components in a case of abuse are potential for abuse in the parents; a special kind of child; and a crisis or a series of crises. The potential for abuse in the parents is a result of how they themselves were reared, their ability to use the help of others, the quality of the marriage relationship, and how they see the child. The special kind of child is one that is different from others—for example, because of hyperactivity or a birth defect. Given the first two components, the third—the crisis—precipitates abuse. Helfer emphasizes that when one crisis is resolved, the risk of abuse is not removed since the next crisis may precipitate a new incident.

Effects of Abuse

The immediate effects of abuse are obvious. A fracture, a burn, or the loss of a limb are there for all to see. The longer term effects are more difficult to determine, but may be equally if not more damaging. Physical abuse often includes brain damage, which is a common cause of mental retardation. A neglected child may suffer permanent damage through, for example, the combination of malnutrition and inadequate medical care at vital developmental stages in his life. The long-term psychological effects of abuse and neglect may be more subtle but equally serious, and may remain with the child for life.

Since the present pitch of awareness of child abuse and neglect is relatively new, there has not been time for extensive study of effects over periods of up to 10 years.

Morse *et al.* (1970) followed up a group of 25 abused children. The abuse incidents took place from two to four-and-a-half years prior to the study, the median was two years, 11 months. Of the 23 still residing in their original homes, eight showed signs of renewed abuse or medical neglect after the original incident. Detailed information was available on the developmental histories and current status of 21 children. Of this group, 15 were below the normal developmental range either intellectually or emotionally: nine were mentally retarded and six were emotionally disturbed. Only seven of the 15 showed developmental improvement: six out of these seven were in foster homes; the other child, though in his parental home, seemed to relate to older siblings rather than the mother. Morse and her co-investigators warned that since the median age of the children at the time of study was only five years, three months, subtle long-term effects of abuse on their emotional and intellectual development might not yet be apparent.

Caffey (1972a) calls attention to the possible harm from shaking a child. He feels that shaking an infant, either in play, accidentally, or as punishment, can result in brain damage as well as damage to the eyes and the long-boned joints. Shaking may thus be a major cause of mental retardation. Male infants are twice as vulnerable to damage as female infants. Caffey reports that abused children often have bilateral subdural hematoma, indicating bleeding on both sides of the brain where it has been injured by collision with the inside of the skull.

Smith (1972) examined 102 cases of unexplained injuries to children under the age of five and analyzed the first 50 cases in detail. He found that only three of them had received medical attention immediately. In 20 cases, the interval between abuse and medical treatment was "several days." In addition to the injury reported, 23 children were found to have old fractures and 25 had bruises of the head.

Bullard *et al.* (1967) followed up 41 patients who had originally been diagnosed as failure-to-thrive; four had been judged abused as well. Six children were found to be retarded, and six to be emotionally disturbed. In addition, 13 of the group, upon reexamination after a minimum of eight months, still warranted the diagnosis of failure to thrive.

Elmer and Gregg (1967) studied a group of 52 abused children. The abusive incidents took place from one year, five months to as much as 10 years before the study. Of the original 52, five were institutionalized, eight were dead, six could not be interviewed because of family objections, and 13 were unavailable for other reasons. Twenty children were examined: five were found to be physically below normal, 10 below normal mentally, eight in poor emotional health, nine suffering speech disorders or problems, and seven with physical defects resulting from the original abuse.

Martin (1973) followed up two groups of abused children. In the first group of 42 children who had been brutally abused, 14 were found to be mentally retarded and 18 were neurologically impaired. The 58 children in the second group had been less severely abused. At the initial examination, 21 had been judged undernourished; 18 exhibited growth retardation at the time of the follow-up. In addition, 31 children were judged to have poorly functioning nervous systems and 18 had serious neurological deficits. Martin added that learning and behavior problems were common in the group.

Glaser *et al.* (1968) evaluated 40 abuse victims out of an original group of 50. The follow-up studies ranged from six months to eight years—an average 40.8 months—after the original incident of abuse. Glaser found that 17 of the children (42.5 percent of the group) were below the height and/or weight standard of the third percentile, or bottom 3 percent, of a normal group. Six children were mentally retarded, four were psychotic or had emotional disorders, and seven had minor behavioral disorders. Of the 19 who were old enough to attend school, seven had failed first grade or were having serious difficulty in doing first-grade work.

Psychological effects of abuse and neglect are more difficult to define and diagnose than are physical effects. The term refers to the existence of psychological abnormalities or impaired social functioning not traceable to a physical injury or abnormality. Many of these effects, however, may result from undetected brain damage. There is also a chance that the circumstances which produced the incident of physical abuse may, in themselves, have long-term psychological effects not detectable at the time of examination. Hard data on psychological effects of abuse are scarce, but there is a growing body of evidence that physical abuse can have a modeling effect on children, predisposing them to become abusive parents. Fontana (1971) reports that abuse is often found in the personal histories of abusive parents. He believes that abused children, if not helped, may become social deviants and abusive parents as adults.

Gelles (1972) indicates that abusive behavior may be traceable to the socialization patterns of the parents. Klein and Stern (1971) note that early deprivation is often an element in the history of an abusive mother. Jenkins *et al.* (1970) give a case history of a nine-year-old boy who battered two sibling infants and diagnoses the behavior as displaced aggression against a brutal stepfather. The boy appeared to model his behavior on the stepfather's violence within the home, but was able to function normally in outside social relationships. Burton (1973), in a study of male juvenile delinquents, noted that a large majority had previously been brutalized at home by adults or older siblings.

Lewis and Sarrel (1969), in a study of sexually abused children, were able to trace mental illness or emotional maladjustment to abusive incidents at a much earlier age. In one case, severe psychological effects detected at the age of 13 were traced to sexual abuse at the age of two.

The short- and long-term effects of child abuse and neglect are well-established. But, in addition, the evidence now accumulating seems to show that abuse has a tendency to recur in vicious cycles. As the child is the father to the man, the abused child may become an abusing parent.

Child Abuse: Pathological Syndrome of Family Interaction

BY ARTHUR H. GREEN, M.D., RICHARD W. GAINES, AND ALICE SANDGRUND, PH.D.

The authors observed patterns of family interaction frequently encountered in 60 cases of child abuse. The maltreatment syndrome is described as the end result of three potentiating factors: the abuse-prone personality of the parent; characteristics of the child that make him vulnerable for scapegoating; and current environmental stress. Role reversal was a prominent feature in the psychodynamic makeup of these families. The parents tended to endow the child with negative characteristics derived from their own experience with rejecting parents.

WITHIN THE DECADE since the pioneering description of the battered child syndrome by Kempe and associates (1), a great variety of behavioral characteristics and psychopathology have been attributed to abusive parents. They have been described as immature (2), impulsive (3), isolated from family and friends (4), rigid and domineering (5), dependent and narcissistic (6), chronically aggressive (5), and prone toward marital difficulties (1). One observer noted that abusive mothers were "masculine" while their husbands were "passive" (7). Role reversal (8, 9) has also been described, by which the abusive parent seeks love and approval from the child. Some investigators (10, 11) have regarded child abuse as a syndrome that appears primarily in families in the lowest socioeconomic levels, while others (4) have cited its occurrence in the middle and upper classes. Other workers (12, 13) maintained that child abuse is psychodynamically determined and is independent of education, race, and socioeconomic level. Some abused children manifest signs of physical neglect, while others are said to receive adequate material and physical care.

More incisive descriptions of the psychopathology of abusing parents and their interaction with their children have been revealed during the course of psychiatric treatment. Steele (13) described a clinical syndrome of parental dysfunction with rather specific key psychodynamics in which he stressed the importance of the parent's closely linked identifications with a harsh, rejecting mother and with a "bad" childhood self-image. These are reenacted in the current child-rearing situation. The abusive parents submit their children to the same traumatic experiences that they themselves had endured, using such defense mechanisms as denial, projection, role reversal, and identification with the aggressor. Galdston (14) reported the treatment of parents of abused preschool children who attended a therapeutic day care center. He emphasized the parents' unresolved oedipal conflicts and phobias in attempting to explain their current difficulties. Feinstein and associates (15) explored in group therapy the behavior of women with infanticidal impulses. These women were characterized by the resentment they showed toward their parents for not satisfying their dependency needs and by their affinity for "maternal" husbands. Many had witnessed or had been subjected to excessive parental violence.

The widely varying behavioral characteristics, personality traits, and psychiatric symptoms described in parents who physically abuse their children suggest that a specific "abusive" personality does not exist. The personality attributes of these parents do not seem to be sufficient to cause child abuse in the absence of potentiating factors within the family. The behavior of the child and the quality of the relationship of the child-abusing parent with the spouse and family must also be weighed as possible contributors to a context in which abuse might occur.

It is the purpose of this study to: 1) describe the most common personality characteristics of the mothers or maternal caretakers of abused children, including the manner in which they perceive themselves and their children; 2) explore the contribution of the child in the abuse process; 3) determine patterns of parent-child interaction in which abuse typically occurs; 4) construct a psychodynamic framework for understanding the phenomenon of child abuse in a disadvantaged population; and 5) assess the environmental factors associated with child abuse.

METHOD

The sample consisted of mothers or maternal caretakers of 60 abused children referred by the Bureau of Child Welfare and the Family Court of New York City. Almost all of the families resided in inner-city ghetto areas and represented the lowest socioeconomic group, with a majority receiving public assistance. All of the

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children were between their fifth and 13th birthdays. The ethnic composition was primarily black and Hispanic (see table 1). The mothers or maternal caretakers were under the supervision of protective service units of the Bureau of Child Welfare or on probation with the Family Court. The criteria for identifying abuse specified that it be of an ongoing or recurrent nature and be confirmed by investigation.

A child psychiatry staff member conducted a structured interview, requiring approximately one and a half hours, with each mother or maternal caretaker to obtain the following information: obstetrical, birth, and perinatal history; family background and early experience; interaction with parents, siblings, and peers; dating, courtship, and marital history; maternal behavioral assessment of the child, including symptoms, school performance and behavior, and peer and family relationships; maternal attitudes toward the abused child and siblings; maternal attitudes toward child rearing and punishment; presence of outstanding maternal psychopathology: psychosis, addiction, alcoholism, etc.; relationships with men (husbands, boyfriends, etc.).

These data were augmented by agency records, which included reports by protective caseworkers and probation officers. Additional information on family psychodynamics and patterns of interaction was obtained from follow-up interviews with approximately 20 percent of the mothers and children who were interested in receiving outpatient treatment. Over half of this group participated in the psychotherapy program, which became a valuable source of information regarding unconscious determinants in the parent-child relationship. The abused children served as subjects in additional studies in which their ego functions, behavior, intelligence, and neurological status were determined (16). These data provided valuable impressions regarding the impact of each child's personality, ego capacity, and developmental status on the mothering process.

RESULTS

The mothers or maternal caretakers of the abused children frequently reported difficulties with their parents. These relationships were marred by criticism, rejection, and physical punishment. They also described current marital discord and stressed the emotional unavailability and physical brutality of their spouses. They complained of an inability to secure help with the burdens of child rearing, which was a consequence of their alienation from their spouses and families. The failure to find support from the environment facilitated turning toward their children for dependency gratification. Their long-term experience of criticism and punishment reinforced their feelings of having been burdensome children and promoted their identification with a hostile, rejecting parental figure.

These women characteristically reported the abused children as aggressive and unmanageable at home and in school. The abused children usually required more attention than their siblings. The mother's perception of the abused child as the most aggressive and demanding of her offspring contributed to the child's scapegoating.

TABLE 1
Sex and Ethnic Background of Abused Children

Ethnic Background	Male (N = 32)		Female (N = 28)	
	Number	Percent	Number	Percent
Black	22	68	17	61
White	5	16	3	11
Hispanic	5	16	8	28

The in-depth exploration of the personality structure of the mothers and their abused children during psychotherapy provided a better understanding of the etiology and psychodynamics of the child abuse syndrome. The focus of the interviews and treatment on patterns of family interaction spanning three generations added a longitudinal perspective to the study.

Child abuse may be construed as the end result of an interaction among three major factors: parents' personality attributes that contribute to their "abuse proneness" and are incompatible with adequate child rearing; characteristics of the child that increase the likelihood of his being abused; and immediate environmental stresses that maximize the burden of child rearing.

Personality Characteristics of Abuse-Prone Parents

1. The parents rely on the child to gratify dependency needs that are unsatisfied in their relationships with their spouses and families. This constitutes role reversal.

2. The parents manifest impaired impulse control based on childhood experience with harsh punishment and identification with violent adult models.

3. The parents are handicapped by a poor self-concept. They feel worthless and devalued, which reflects the rejection and criticism accorded them by adults during their own childhood.

4. They display disturbances in identity formation. Identifications are shifting and unstable and are dominated by hostile introjects derived from the internalization of "bad" self and object representations of early childhood.

5. They respond to assaults on their fragile self-esteem with a compensatory adaptation. Because of their need to maintain a positive facade, they must desperately defend themselves against the awareness of underlying feelings of worthlessness by the frequent use of projection and externalization as defense mechanisms.

6. The projection of negative parental attributes onto the child causes him to be misperceived and used as a scapegoat in order to bear the brunt of the parent's aggression.

Case 1. Sonia, a six-year-old Puerto Rican girl, was severely beaten by her mother when she was four, resulting in a fractured femur. Sonia was the daughter of Ms. G.'s first husband, who, after frequent quarreling, drinking, and "running around," left her when Sonia was one year old. Ms. G. subsequently entered into a common-law relationship with a man who fathered her two young boys.

Ms. G. initially married in order to escape from her brutal godparents, who had raised her since the age of 18 months after her mother had abandoned her. They had been extremely punitive and restrictive. Ms. G. remembered one occasion in which her godfather had broken a flowerpot over her head. Ms. G.'s marriage was arranged by the godparents. She went to work in a factory and was virtually ignored by her husband. She soon became pregnant but did not want a child since her husband spent no time with her. He deserted a first time when she was six weeks pregnant, and Ms. G. moved in with her sister-in-law to have the baby. She hoped for a boy, stating, "I don't like girls. Boys are more interesting."

In addition to displacing her rage toward her ex-husband and godparents onto Sonia, Ms. G. obviously identified with her little girl and brutalized her in the same manner as her own experience with her godparents. She described the following feelings toward Sonia: "Since she was born, I let out all the anger and frustration that I had in myself on her. Whenever she came to me, I sent her away with a beating." It is worth noting that Ms. G.'s relationship with her male children is better.

Characteristics of the Child

1. Pathological traits that might constitute an additional stress for "average" nonabusive parents include extreme physical or psychological deviance of the child. Children with major physical defects and congenital anomalies, as well as psychotic, retarded, or brain-damaged youngsters, are tolerated poorly by narcissistic parents, who regard them as new editions of their own defective self-image. These children are also extremely burdensome and increase the task of child rearing.

Case 2. Martin, a seven-year-old white boy, was referred to the Bureau of Child Welfare by school personnel, who noticed numerous marks on his body. Ms. C., his mother, admitted hitting him daily, often with a broomstick, because of his disruptive behavior, which included restlessness, excessive demands for attention, silliness, and his failure to learn. She felt that Martin's misbehavior was an effort to punish her. Ms. C. complained about her alcoholic husband's failure to involve himself with Martin and her three other young children.

Ms. C. reported an unhappy childhood marked by a frustrating relationship with her mother, who consistently criticized and punished her while showing affection to her four brothers. Her mother forced her out of the house when she was 16 years old.

Psychiatric examination of Martin revealed a clumsy, awkward child who was agitated and hyperactive. His speech was grossly impaired, and he was preoccupied with uncontrollable aggressive and destructive fantasies. There was a pronounced lag in his acquisition of speech and motor functions. The neurological examination indicated impaired motor coordination and perceptual motor deficits, with an abnormal EEG. Full-scale IQ on the Wechsler Intelligence Scale for Children (WISC) was 72. Ms. C. admitted disliking Martin from birth because he was "difficult" and demanded so much attention.

Another group of children with pathological traits that might constitute additional stress are those who respond poorly to nurturance. These may be colicky, irritable, and hypertonic infants who are difficult to satisfy and comfort. The mothers perceive their unresponsiveness as a rejection reminiscent of experiences with their own parents and intensifying their sense of inadequacy.

Older children who display difficulties with impulse control also comprise part of this group. They manifest such behavior problems as lying, stealing, and assaultiveness and are often disruptive in school. They relate to significant objects in a provocative, sado-masochistic fashion. They clearly find some gratification in their ability to elicit punishment from the abusive parent.

2. Normal or "accidental" traits, which are misperceived by, or only attain special significance for, abuse-prone parents, include the child who is identified with a hated person or situation. For example, a mother will beat a child whose conception forced her into a premature and unhappy marriage. Another mother will abuse a child who resembles a despised ex-husband or boyfriend.

Case 3. Sam, a nine-year-old Jamaican boy, was severely beaten with a broomstick by his mother for distributing the family's food stamps at school. This event occurred shortly after his return from Jamaica where he had been cared for by several "babysitters" since the age of two when his mother left him and his year-old brother in order to go to New York. Ms. R. had beaten Sam frequently as an infant before she left him, and he and his brother were given regular severe beatings by the woman who was responsible for most of their care. Ms. R. subsequently had three children out of wedlock in New York. She readily agreed to allow Sam to live with her own mother after she was reported to the Bureau of Child Welfare.

Ms. R. had conceived Sam when she was 16 and had broken off with her boyfriend before she was aware of the pregnancy. Her mother became enraged, subjected her to beatings, and put her out of the house before she had the baby. Another son was born 16 months later, and Ms. R. left for New York shortly thereafter. Ms. R. recently married the father of her youngest child and has not visited Sam since he was placed with the grandmother. Ms. R. could cope with this unfortunate child, whom she unconsciously blamed for her mother's abuse and abandonment of her, only by subjecting him to the same punishment.

Also included in the group of children with misperceived normal traits is the child whose parent remarries and who is subsequently regarded by the stepparent as an unwelcome and burdensome stepchild. The stepchild is often treated as a sibling rival who threatens the stepparent's dependency on the mate. The stepchild also becomes a convenient target for the stepparent's hostility directed originally toward the spouse.

Case 4. Don, an 11-year-old black child, was severely beaten by his stepfather, resulting in multiple contusions and lacerations of his back and buttocks that necessitated his hospitalization. Don is an only child who had lived with his mother and maternal grandparents on a farm in the South. Don remained with his grandparents when his mother came to New York to find employment. When his mother married Mr. P., Don, then seven, came to New York to live with them. Since his arrival, Don has been a source of constant friction between his mother and stepfather. The latter accused his wife of spoiling Don and failing to curb his "meanness." Mr. P. complained that Don was a financial burden and subjected him to frequent and excessive beatings. When Don's mother would intervene to protect him, Mr. P. threatened to leave if the boy was not sent back to the grandparents.

A young child who exhibits age-appropriate sexual or aggressive behavior that is considered to be abnormal is also included in this group of abused children. This behavior cannot be tolerated because it evokes the parent's own unacceptable impulses that are excluded from consciousness and ascribed to the child by means of denial and projection. Sexual acting out in older children will often elicit physical abuse from a parent who identifies with these unacceptable impulses.

Case 5. Debby P., a seven-year-old black girl, had been subjected to recurrent abuse by her mother for alleged mutual masturbation with her five-year-old sister. Ms. P. habitually examined Debby's panties for stains or some other evidence of masturbation. She would then accuse her and punish her with a beating. The abuse was accompanied by threats of abandonment.

Ms. P.'s childhood had been marred by her mother's abandonment and a punitive relationship with her grandmother, who used to beat Ms. P. and her twin sister while they slept. At the age of 14, Ms. P. was placed in a training school, where she had engaged in some homosexual activity. Debby's masturbation undoubtedly evoked her mother's long-standing guilt and anxiety over homosexuality, which she managed by attacking Debby with the full fury of her punitive superego.

Current Environmental Stress

Environmental stress includes current events that widen the discrepancy between the limited capacity of the parents and increased child-rearing pressures. The stress may consist of a diminishing of child-rearing resources, which might be due to a spouse's illness or desertion or to the unavailability of an earlier caretaker, such as a neighbor or some other family member.

Case 6. Calvin, a 10-year-old black boy, was referred to the Bureau of Child Welfare by the school guidance counselor because bruises, scars, and cuts were observed all over his body. These resulted from beatings inflicted by his father, Mr. A. An alcoholic, Mr. A. began to beat Calvin and his two younger children regularly with a knotted ironing cord two years before, after he had assumed full-time child-care responsibility when his wife became incapacitated following a stroke. Mr. A. decided to leave his job and seek public assistance in order to take care of the three children. These arrangements broke down, however, when the pressures of child care caused an increase in Mr. A.'s drinking, which was accompanied by a progressive loss of impulse control.

Another environmental stress is the actual or threatened loss of a key relationship that provides the parent with emotional security and dependency gratification. This may occur when the spouse becomes physically or emotionally unavailable or when ties with parents or important relatives are severed due to estrangement, illness, or death. Additional child-rearing pressures, such as the birth of another child, children becoming ill, or assuming the temporary care of other children occasioned by illness or death of friends or relatives, create environmental stress that might lead to child abuse.

DISCUSSION

One might summarize the typical psychodynamic pattern operant in the abusive mother or maternal caretaker during interaction with the scapegoated child as follows:

The increased demand for nurturing by the child intensifies the mother's own unsatisfied dependency longings. Since the mother is usually unable to receive gratification and support from her spouse and family, she turns to the child for the satisfaction of these needs. These claims on the child are inevitably frustrated, since they are incompatible with the satisfaction of the child's own urgent demands. At this point the mother unconsciously equates the child with her own critical, rejecting mother who never could satisfy her.

The mother passively reenacts with the abused child the rejection and humiliation she originally experienced with her own mother. The resulting anxiety, guilt, and loss of self-esteem threaten the mother's fragile, narcissistic equilibrium. Her "bad" self-image and unacceptable feelings become intolerable and are displaced onto the child with the aid of such defense mechanisms as denial, projection, and externalization. With this shift, the mother assumes the identification with her "bad" mother, representing her punitive superego, and attacks her child, who now symbolizes her past and current inadequacies. This identification with the aggressive mother allows her to actively master the traumatic rejection she had passively experienced as a child at the hands of her own mother. Signs of poor responsiveness, failure to thrive, or deviancy on the child's part may increase the mother's feelings of inadequacy and the transfer of unacceptable maternal traits onto the child.

In addition to representing the "bad mother" and "bad childhood self" in the mother's unconscious, the abused child may become linked to other individuals who have been associated with ambivalence and/or rejection. The child may symbolize a despised former mate or lover, a hated sibling rival, or a disappointing parental substitute, but all of these additional objects retain a tie to the original "bad," rejecting mother.

Nonabusive mothers whose children have been battered by husbands or boyfriends exhibit a slight variation in the psychodynamic pattern. The interaction between mother and child begins in a similar fashion as the mother endows the child with the attributes of her own rejecting mother. However, the resulting "bad" childhood self-image derived from her mother is partly maintained and partly transferred to the child, while the internalized "bad mother" is projected onto the abusive mate. The mother identifies primarily with the "child victim" rather than with the "mother aggressor."

These women submit to the physical cruelty of their mates as a masochistic repetition of their childhood victimization by rejecting, hostile parents. The pain-dependent attachment to the spouse serves as a defense against their hostility toward the child. This is confirmed by the tenacity with which these women cling to such brutal and humiliating partners and by their tendency to assume the abusive role if the spouse leaves.

CONCLUSIONS

Child abuse may be regarded as a dysfunction of parenting in which the parent misperceives the child due to the parent's own frustrating childhood experiences. In beating the child, the parent attempts to actively master the trauma he passively endured during his early life. The etiology of child abuse is based upon an interaction among three factors: the personality traits of the parents that contribute to "abuse proneness"; the child's characteristics that enhance his scapegoating; and the increased demand for child care exerted by the environment.

Any logical plan for the prevention or treatment of child abuse must be designed to modify these crucial variables and to acknowledge the intrusion of the past into the parent's current relationship with the abused child.

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*The Child Sex Victim: Social, Psychological and Legal Perspectives

LEROY G. SCHULTZ

The skill of the social worker faces an extreme test in preventing or reducing trauma in children subjected to sex offenses, particularly in cases that involve court proceedings. This paper discusses aspects of sex-offense cases and social work techniques in handling them.

The need for treatment or social service for the victims of sexual offenses is not adequately reported or documented in social work literature(4) and most of the standard professional textbooks dealing with children's services do not cover the topic.(13) Apparently the social work practitioner does not receive many case referrals from law enforcement agencies, courts, hospitals or victims' families, or the helping professions have assumed that such problems are the concern of the medical profession only, specifically the psychiatrist or pediatrician; or the victim-cases that occur in social work caseloads have not been researched and published. Possible, too, is that sex offenders' victims do not want or need treatment or social service, or that they and their families are too embarrassed to approach treatment agencies.

The incidence of sexual victimization is difficult to measure accurately. There is no national statistical system recording the incidence. Estimates run from 4000 cases of child-sex victimization a year in large

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cities.(4:Protecting Child Victims, 2) a national average of over 3000 cases of incest a year(4:Child Victims of Incest, 5) and between 200,000(4:Sexual Abuse, 10) and 500,000(8:191) cases a year of sexual assaults on female children (ages 4-13). National estimates*of sexual assaults on male children are nonexistent.

Male sexual attacks on females have been increasingly reported to law enforcement agencies in the last year, with three rapes reported every hour.(4:Sutherland,503-511) To put it another way, the likelihood of a female being raped by a male is 1 in 550 a year. Lesbian assaults are almost unheard of, but perhaps do occur in female institutions.(12:436-439) Male rape is common in male juvenile correctional institutions(5:8-18) and may be as statistically prevalent as female rape at large. As much as possibly 50% of all sex crime is not reported to police by the victim,(2:16-33) suggesting that the incidence of sex offenses is much higher than official statistics indicate. The victim may be seen by a family physician or in the emergency room of the local hospital, and therefore no public record is available.

Victim Topology

Sexual victims may be placed upon a continuum from totally accidental victimization at one end to seductive partner at the other. Many victims consent to the offense or offer no resistance, and both victim and offender are symbiotic, or form a cooperative dyad. This relationship shapes the victim's attitude toward the sexual offense and the offender, as well as her willingness to testify against him, with possible subsequent guilt feelings. What type of treatment a victim may request or need appears related to where the victim is situated along the victimization continuum, with the important factors centered around degree of force employed and the intensity of the victim-offender relationship prior to the offense.

In past sexual research, young female victims were described as having a "collaborative" role in the offense in 7.8% of 330 offenses,(8:176) as "nonobjecting" in 40% of 1994 offenses,(17:83) as "encouraging" to the offender in from 66% to 95% of all sex offenses,(9:747) as fully "participating" in 60% of 73 offenses(20:1) and as "seducers" in 21% of 185 offenses.(11:296) Although victim precipitation, cooperation, invitation or seduction presents a problem for the courts in assessing degree of guilt and punishment for the offender (usually relieving him of responsibility), the social service agencies must deal with this type of child as a sex delinquent. In general, physical force on child-victims plays a small role in the offenses (4% of 333 offenses(8:184)) and this may be related to the fact that most offenses against children are with persons

they have some relationship with, such as a family member, a family friend, a neighbor or a teacher.(10:11) so that physical force is unnecessary to carry out the offense, and also to the fact that the specific type of sex-offense does not require physical violence to complete. In the Gagnon study 1.9% of the victims sustained a forced act of penetration and 2.7% a general forceful attack on the whole body.(8:18) The major sexual activity between victim and offender was characterized by exhibition of sexual organs, genital and nongenital petting or fondling, mouth-genital contacts and attempted penetration without force.

If no force is employed and the act takes place with an acquaintance, it probably will not be reported to the police. Important, too, is that despite the use of violence, some victims may not report the offense out of shame, embarrassment, mistrust of police, or fear of exposure to the community and one's relatives and friends.

Effects of Victimization

The general direct effects of victimization upon children have been exaggerated in the literature. Generally, sexual assaults on children do not have an excessively unsettling effect on the child's personality development.(2:155) nor a serious affect on adult adjustment.(8:188) Of the 3% of offenses against children involving physical force and penetration, physical results may involve sex-organ injury or rupture, general body injury such as bruises, bites or scratches, venereal disease, valvitis or pregnancy. Problems of this type should be treated in the hospital, clinic or family physician's office.

Psychosocial effects are not so readily assessed as the physical. The psychosocial negative effects are related to the amount of violence employed, the depth of the child's relationship to the offender and the family's and society's reaction to the offense. Immediate reaction to the offense may range from simple fright, such as when the child encounters something new but unpleasant, to vomiting and hysteria. Some react without fear or guilt and some report being sexually aroused. In the Gibbons-Prince study, 43% of 82 cases showed no overt disturbance after the sex act; in 16% the child appeared unsettled, with behavior problems; 14% needed professional treatment, and 6% needed correctional institutionalization.(10:13) In general, the best recovery is made by the child who is sexually assaulted without violence by a stranger.

The child's relationship to the offender is extremely important in understanding the offense dynamics and aftereffects. Most victim children allow or seek out affectionate behavior from their offenders, many feel kind and loving toward them and have established meaningful relationships with them, usually over a period of years, with frequent sexual behavior. This situation is particularly true in family incest, where a daughter will not place criminal charges against the father for fear of being responsible for parental separation or divorce, the loss of father, or seeing him sentenced to a correctional institution, or out of oepidal guilt. Female victims are sometimes blamed by their mothers for breaking up the family. The same holds true for the female adolescent victims who manifest strong resistance to bringing charges against "steady" boyfriends. Sometimes victims engaged in behavior that was seductive, out of affectionate feelings, but were naive about its potential as a sexual stimulus, and once the offense was committed felt betrayed, shocked, and generally, had a negative reaction. The child victim may also feel guilt if she reports some gratification from being the object of love and attention by an older person, whom her family and society suddenly condemn.

By far the greatest potential damage to the child's personality is caused by society and the victim's parents, as a result of 1) the need to use the victim to prosecute the offender, and 2) the need of parents to prove to themselves, family, neighborhood and society that the victim was free of voluntary participation and that they were not failures as parents.

Society, through its system of administering justice, requires that a person charged with an offense has a right to trial and to confront and cross-examine those who have brought the charges. What does harm to the victim is our society's need to have her repeat the details of the offense several times, to police, prosecutors and to the jury, sometimes with the assailant present. What perhaps in the child's mind is a short-lived traumatic event with no permanent consequences is thus placed out of proportion to its importance, and forces the child to reorientate his or her ideas toward an adult interpretation of the offense, and the child's role in punishing the offender. Most police and prosecutors have no training in nondamaging methods of interviewing children, and tend to use adversary approaches appropriate for adults. The offender's lawyer has the duty of defending the client with every possible tool, and in so doing may contribute to or induce emotional damage to the victim by attempting to show that the victim is incompetent, seductive, malicious or a "Lolita," or has brought false charges.(15:105-136) The dilemma here is the need to protect the child from the potential trauma of legal proceedings, but at the same time to convict and rehabilitate the offender. This dilemma can be somewhat reduced by using special interrogation. Even so, many parents may refuse to bring in the legal authorities for fear of reputational damage to the child and family. If courts cannot eliminate the trauma of testifying, nonreporting may be the best choice.

It is clear from studies of child sexual victims that it is not the sexual assault that usually creates trauma, but the child's parents' behavior upon its discovery, and the effect of this on the child.(10:6) Parents overreact, develop hysteria, attack the assailant, attack the child victim, berate and punish the victim, demand that the child victim testify that the attack was unprovoked, or threaten court personnel unless the offender is sentenced speedily. The Gibbons study indicated that 26% of the parents engaged in behavior that aggravated the sex-offense situation or exploited the child's situation for social benefit.(10:14-15) As soon as possible after the offense, parents will need help to accept the offense in such a way that horror, panic and fright are not communicated to the child, so as to create trauma where none existed. In most instances sexual trauma, unless reinforced by court testifying or parental overreaction, produces few permanent consequences.

Social Work Treatment

The Child Victim

Once the sexual victim has received medical attention(7:431-438) if it is needed, and has been referred to the social agency, the social worker is faced with helping the family decide on the desirability of reporting the offense to the police. A refusal to report is based upon reluctance to repeat details of the offense to others, a desire to avoid publicity, social stigma or revenge from others, or a belief by the victim or parents that the incident created so much emotional disturbance that accurate recounting of the offense is unlikely. The pro and con of these issues must be assessed and discussed with victim and family to help them make a decision. A decision as to the effects upon the victim involves whether charges are filed and the child is a witness, as against the safety of the community of potential victims if the offender is not prosecuted. If the family and victim decide to bring charges, they should be instructed upon how to do this, and perhaps the social worker should accompany them to the police. If they have decided to report the incident, the family and victim should be instructed to do so as soon as possible. Some effort should be made to make sure that the "offense" is not a product of the child's imagination or that charges are being made out of spite or retaliation. Instruction should be given to preserve any physical evidence, such as blood or semen stains on clothing or sheets.

Regrettably, in some jurisdictions the child may be required to testify against the offender without the consent of the child or family, and may be placed in detention until the trial. In some situations the prosecutor feels that the alleged offender poses a dangerous threat to the community and that the child's testimony is imperative to conviction. In some instances the child is placed in detention or in a foster home because a parent is the offender or because a neglect charge is filed against the parents.

If the jurisdiction requires the child's testimony, or the family or victim decides to prosecute, the social worker should prepare them for the court experience, to ease anxieties about legal proceedings. This can be done through traditional role playing, behavior-rehearsal techniques, and mock trials. Efforts should be made to speed the legal proceedings and to insure privacy in court proceedings. The social worker should accompany the child and family at every court appearance.

Casework services for victim and parents should be supportive. The parents will need firm assistance in taking a constructive and nondamaging attitude toward the offense, its social repercussions, the possible effects upon the victim, and the role they can play in the reduction of trauma. They may need direction on "playing down" (deconditioning) the significance of the offense. Many child victims are seeking affection not given by the family or are seeking substitute attachments to compensate for insecurity in the family. In such cases mothers may need advice on overcoming maternal-affection insufficiency. Parents will need an opportunity to ventilate feelings, particularly if there is guilt about parental contribution or negligence.

Child victims may need sympathetic casework assistance in understanding what happened in simple anatomical, sexual terms, and in ventilating feelings of anger, guilt and helplessness.

Many child victims are from homes that are disorganized and lack adequate supervision. Some will require sex education. Some will have been socialized within homes and neighborhoods with sex codes different from the code reflected in law; others will indicate poor impulse control related to deprivation, rejection and maternal inconsistency. These factors may later be the main problem for social work focus and the whole range of traditional protective services of correction and prevention. Incest cases pose a special problem for the family in that a girl victim may have developed a strong affection for her father over a long period of time.(19:137-135) Courts and social agencies are quick to separate the family members, with little preparation for the child's loss of the source of her affection.

Marked efforts at preventing a second victimization or preventing another family member's being victimized should be made through educational measures that are geared to the child's needs and intellectual level and that avoid creating unwarranted fears and anxiety. Particularly to be avoided are lengthy descriptions of sexual pathology or "dirty old men" generalizations that compound the problem. The relative harmlessness to the victim of certain types of sexual behavior—exhibitionism, for example—should be recognized. The feeling that the child can share sexual ideas and experience with open-minded parents may prevent concealment of damaging experiences.

Reducing the Trauma of Testifying

Most children probably have the strength, stability and home support that enable them to endure the temporary stress of repeating details of the offense before a police officer, prosecutor, or jury if they are accompanied by a social worker or other professional, but for some the court proceedings are themselves the chief traumatic event. There appears to be no effective way of determining which children can sustain the court process or of predicting its long-range effects. Fortunately, the cases in which repetitious testimony is required are few. About 80% to 90% of all criminal defendants plead guilty without a trial(16:780) so that the child's testimony or appearance in court is not required. In these cases the child will be spared all but the police, warrant office and grand jury experience. It is the court experience, with its adversary nature, that poses the greatest potential trauma genesis. Where violence was used by the offender, he may not want to risk a jury trial, particularly in states in which the jury determines guilt and sets the sentence, and he has an advantage in bargaining for a lighter sentence by pleading guilty. It is when the issue of victim participation or seduction arises that defendants may demand a trial in order to impress the jury with victimogenetic factors in cases of victims over age 14.

The fact that as many as 50% of sex victims or their parents do not report the offenses to legal authorities may be a result of the child's contributory behavior or a parental view that the police and court experience will be damaging. The result is that many perhaps dangerous sex offenders are not apprehended. To meet such a situation, there is need for reform in the methods of child interrogation following the offense. The mental health of the victim may be in the hands of untrained police officers, sheriffs or court personnel.

Since most counties in the United States have at least one trained professional—the child welfare worker attached to the county or regional welfare office—he may be the most practical resource for the professional task of interviewing the child victim. It seems it would be more effective to teach the social worker a legal perspective than to teach police and prosecutor a mental health orientation.(6:133-160)

One country, Israel, has a policy under which a professional person interviews the child victim under age 14 and decides if the child's mental health will be affected by reporting the details of the offense in open court.(18:109) If he decides that the court experience would be harmful to the child, the social worker, instead of the child, may be cross-examined in court. The defendant cannot be convicted on the evidence of the social worker unless it is supported by other evidence. This procedure violates the fundamental rule of the inadmissibility of hearsay evidence and deprives the accused of the right to cross-examine the accuser. The problem centers around a balance between justice to the child and to the offender.

In divorce proceedings, the social consequences to the dependent children involved are taken into consideration, and perhaps this concept can be extended to sex offenses against children—although the analogy is far from exact. Although the welfare and interests of the child-victim and the offender seem to clash head-on, the legal rights of either cannot be abridged. The Israeli law cannot be adopted here because it would violate basic rights of the accused to face his accuser, the right to cross-examine, the right to exclude hearsay evidence and the right to equal protection of the law. In addition, Israel has a rigid sex code and a negative attitude toward sexuality, stemming from the nation's religious heritage, that itself may instigate the trauma.

Interviewing the Victim

An appointment should be prearranged with the victim and parents in their home at a nonschool hour. Having the interview in the victim's home provides a familiar, relaxed atmosphere, and places no burden of travel to a strange, perhaps frightening, office or building. The purpose of the interview should be stressed in appropriate language. My experience has been that if the child has been informed by his parents that he has nothing to fear, i.e., that they endorse the interview, and has been told to cooperate with the social worker, much has already been accomplished. The victim and parents should always be interviewed separately, out of hearing and viewing distance of each other. The presence of another person may induce bias, distortions or omissions in the version of the offense and its consequence. The manner and choice of language should be natural and appropriate to the child's age, intelligence and social class. Slang or childish terms may be appropriate.

Reasonable neutrality is basic and the interviewer should avoid prematurely taking sides with or against the child, the child's parents or the defendant. Some sex victims feel outraged, demoralized, defensive or outcast. Mutual trust and confidence may be established by sympathetic questions, encouragement and assurance. Acceptance of the victim's opposition to the interview should be made explicit by the interviewer. Some victims will welcome an opportunity to express their views freely once the purpose of the interview is understood.

The interview should begin with consideration of objective, tangible and physical elements of the offense. After establishing a degree of rapport, the social worker can proceed to emotional considerations, within the capacity of the victim to tolerate the discussion. The interviewer must be alert to the possibility of disturbing the interview relationship by questions that are too abrupt, rapid or demanding. Conflicts, gaps or mistruths should be clarified in a moderate, helpful, nonemotional manner.

If the case is processed through the courts, the social worker should see as his function the preparation of the victim and his family for the court experience. He may seek to have the case docketed for early handling, oppose unreasonable delays or adjournments, and request that the case be heard in chambers or that the public be excluded from the courtroom. He may discuss with the prosecution the advantages of bargaining for sentence or accepting a guilty plea. After disposition of the case, the social worker's task is to minimize the damaging offense and court effects rehabilitatively, or, if severe trauma results, to refer the family to a psychiatric clinic or family physician.

Conclusion

1) Probably less than 5% of all child sex victims are assaulted by violence or penetration.(14:16-24)

2) Most of the child sex victims who would be damaged by the court experience have indicated personality disturbances before the offense.

3) Most of the sexually assaulted children, where no violence was employed, were engaging in affection-seeking behavior, and do not perceive the event as traumatic.

4) Guilt in sexual victims is often absent, but may be engendered by parents, courts or community *after the fact*.

5) Most sexual assaults do not affect the child's personality development, particularly where neither violence nor court appearance has occurred.

6) Where a court appearance is necessary to convict an offender who is dangerous to the community, and such an appearance results in mental or social damage, the child should receive victim compensation from the state or court. Courts should experiment with the use of one-way mirrors or screens and television to control for trauma.

7) With the increase in sex education in elementary schools, reported victimization may decrease. (Some sex-education classes show the film, "Meeting Strangers: Red Light, Green Light" [20 minutes, 1969—BFA Educational Media, 2211 Michigan Ave., Santa Monica, Calif. 90404] as a sex-crime preventive).

8) With rapid value change regarding sexuality, the concept of what constitutes a sexual offense may change.

9) Communities need sociomedical services for the victims of sexual offenses, and specially trained social workers to handle the child victim's court appearance, to prevent or control trauma.

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B. Child Abuse and the Law

CHILD ABUSE LEGISLATION
IN THE 1970's

Revised Edition

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CHILD ABUSE LEGISLATION IN THE 1970's

SECTION I

THE LAWS FOR REPORTING CHILD ABUSE

Few recent social causes have aroused public sensibility, or created as much concern, as has our present awareness that child abuse is a shocking reality and a problem which knows no bounds in relation to economic or educational levels of parents.

While the current wave of public concern is of comparatively recent origin, the problem itself is old to protective service workers. The first recorded child protective case – The Mary Ellen Case, New York City, 1874 – involved a grossly abused child whose plight became a "cause celebre" when laws to protect animals had to be invoked in her behalf because no laws to protect children had as yet been enacted.

Public indignation at parental disregard of the rights of children and for their traditional protective role is frequently turned toward punitive action against parents who transgress ideals about family responsibility for children. All too frequently, however, the need for constructive planning and the need for services on behalf of the abused child are given only secondary consideration because of the hostility engendered in the process of pursuing sanctions against offending parents.

SIZE OF THE PROBLEM

There are no accurate national statistics on the incidence of child abuse. Several studies serve to index the size of the problem.

Of particular significance is a 1962 study by the Children's Division of The American Humane Association. That study reviewed cases of child abuse reported in United States newspapers. The study amassed information on 662 incidents culled from newspapers in 48 states. The cases represented the grossest types of child abuse – situations which were reported to law enforcement authorities and which were deemed "newsworthy" by the local press. The severity of abuse reported may be judged from the fact that in 178 of the cases, almost one-fourth of the total, the child died from the injuries.

The 662 cases studied represent only that portion of child abuse incidence which was identified and reported by the press. For each such case making the headlines there may well be a hundred or more, unseen, unreported and unidentified.

Educated estimates place the probable national incidence of serious child abuse at more than 10,000 cases a year. There are, no doubt, many additional thousands of cases in which the mistreatment is of less dangerous proportions. David Gil's nationwide study at Brandeis University produced a finding of 9,300 cases of reported child abuse for the nation in 1967 with "approximately 6,000 cases of confirmed abuse." Cases were reported to that study by central registries in the states and territories.

The Children's Division of The American Humane Association, through a grant from the United States Children's Bureau and the Office of Child Development, is in the initial stages of establishing a national information center on child abuse and neglect. It will serve as a national clearinghouse to collect information on abuse and neglect on a systematic, on-going basis. It is hoped that through the operation of the center the magnitude of the abuse problem in the United States can be more accurately documented. The Clearinghouse should be operational early in 1974.

But even with a means of obtaining an accurate count of reported child abuse cases, the essential question remains: How to find and identify the vast number of child abuse cases which are hidden from public view and thus not reported. Not only did this question pose the problem which prompted the move for mandatory reporting statutes, but it continues to be the principal subject of amendatory legislation.

WHY A REPORTING LAW?

The need to discover and identify child victims of abuse is the compelling reason for devising a casefinding tool such as the reporting law. Medical personnel came to be selected as the principal target group of the law's mandate as a result of ferment within medical circles where research and study was producing irrefutable evidence that some cases of child abuse can be determined by medical diagnosis.

Numerous articles in medical journals implore practitioners to exercise great care when examining children brought to them for treatment of injuries. All too frequently, they are told, doctors accept glib stories about such injuries resulting from accidental cause. The use of X-rays and a study of all symptoms may reveal findings inconsistent with the history given, and may provide the doctor with reasonable cause to suspect inflicted, rather than accidental, injury. Failure to recognize the "Battered Child Syndrome" could subject the child to additional or repeated injury or even death.

The logic and force of medical concern as expressed in the literature has focused attention on the doctor as the probable first responsible contact with child victims of abuse. Doctors may be the first "outsiders" with opportunity to see and examine the child, and the first competent persons capable of assuming responsibility for positive action on behalf of the child. Thus, they are seen as the best resource for early identification and reporting of such cases as are brought to them for treatment.

But are doctors willing to voice their suspicions by reporting these cases when the diagnosis of inflicted injuries is not clear cut – particularly in the face of a denial by the parents? Would such reporting expose doctors to the possibility of a legal action for money damages? Would doctors find that such reporting runs counter to ethical considerations in regard to privileged communication between doctor and patient?

To overcome these blocks to free reporting, legislation has been enacted making reporting of child abuse mandatory and providing immunity from legal action to persons making a report. These laws also include a waiver of the doctor-patient privilege. Waiver of the husband-wife privilege frees a spouse to testify about abuse committed by the other spouse.

Procedural matters regarding the manner and method of reporting are dealt with. An immediate oral report by telephone to be followed by a written report is commonly required. Also included are requirements covering content, i.e., age of the child, names, addresses, etc.

PHILOSOPHY AND PURPOSE OF REPORTING LAWS

The most important consideration in the concept of mandatory reporting is a statement of the purpose to be served by the report. Obviously, the core objective is early identification of children who have been physically abused, so that they can be (1) treated for present injuries and (2) protected from further abuse.

Achieving the first prong of this objective—treating children's injuries—presents no serious problem except in cases where parents, for religious or other scruples, may refuse permission for needed medical care. Depending on the specifics of each such case, that problem can be dealt with by invoking the authority of the juvenile court to order necessary medical care over parental objections.

The second part of the objective is one where different approaches may be, and are being, used. Here we are looking at the pattern a community creates for treating the situation so as to protect the child from further injury. Consideration of this point requires that we examine what process the community employs to prevent additional abuse.

THE EMOTIONAL CLIMATE OFTEN SUPPORTS PROSECUTION

As noted earlier, the general attitude toward the problem of child abuse, and a common reaction of people when confronted with the brutal facts, is shock and anger. A natural consequence is the desire to exact retribution—to punish unnatural parents for their acts of cruelty.

Where that philosophy prevails, reporting legislation is viewed as a tool for identifying parents who mistreat children so that society may deal with them for the crime of child abuse.

What are the merits of this approach? On the positive side, we can say that justice, in the strict legal sense, is sought to be served. The negatives, however, are many.

Criminal prosecution requires proof through evidence which establishes the culpability of a parent beyond a reasonable doubt. Because these acts usually take place in the privacy of the home, without outside witnesses, and because parents, with rare exception, are mutually protective in these cases, lack of evidence makes it impossible to identify which parent was the offender, or to sustain the legal burden of proof. An unsuccessful prosecution may subject the child victim to increased hazards for he will be exposed to the care of a parent who, in addition to his other problems, may now be embittered by his experience with police and court. A disturbed parent may view the prosecution's failure to find him guilty of child abuse as a license to continue to abuse.

Other factors mitigate against viewing mandatory reporting as a means for identifying and prosecuting offending parents. If seeking medical attention for the injured child may expose a parent to the possibility of criminal prosecution, fear of the consequences may prevent taking a child for medical help until the situation becomes acute—or, perhaps, until too late to help the child. Of equal weight is the concern of doctors who may resist reporting cases if by so doing they become involved as witnesses in a criminal proceeding against the parents. Because doctors identify with the "helping" ethic, they would find repugnant anything which places them in a punitive role. The net result could be a stalemate—and a defeat of the law's objective to encourage reporting and early casefinding.

An additional consideration is the fact that punishment of abusing parents through criminal prosecution does not correct the fundamental cause of their behavior. If we recognize the mental, physical and emotional inadequacies of these people then we must recognize that prosecution and punishment will not produce true change in their behavior. At best it can only produce surface compliance, with deeper motivational forces remaining untreated and the emotional damage to their personality becoming greater as a result of the punitive experience.

This is not to say that parents should never be prosecuted for child abuse. Certainly, the community has a duty to act against parents who commit heinous criminal acts against children. Where a felony has been committed this duty cannot be evaded. But the decision of whether or not to prosecute in a given case should rest with the county prosecutor. In making this decision he must also consider what happens to children. No decision to prosecute parents can afford to overlook the necessity for adequate planning for the abused child and other children in the family.

SOCIAL PLANNING FOR CHILDREN MEETS THEIR NEEDS BEST

The second approach is rooted in a philosophy which sees the purpose of casefinding to be the discovery of children who, because of abuse, need the care and protection of the community. The community carries out this responsibility by making available the protective social services which will (1) prevent further abuse of the child and (2) meet the child's needs through social services and social planning to assure maximum protection.

This approach is served best if the reporting, at the outset, is directed to the child protective program in the community. Such services are usually found in the public child welfare agency.

Child protective programs are especially qualified to "reach out" to families where children are neglected or abused. Their functional responsibility requires that they:

(1) explore and determine the facts of neglect or abuse,
(2) assess and evaluate the damage to children,
(3) initiate appropriate social work services to remedy the situation, and,
(4) invoke the authority of the juvenile court in those situations where removal from parental custody must be sought in the best interests of children.

The "helping-through-social-services" philosophy is stretched to include the parents. This is based on the recognition that destructive parental behavior is symptomatic of deeper emotional problems. Rarely is child abuse the product of wanton, willful or deliberate acts of cruelty. It results from emotional immaturity and from lack of capacity for coping with the pressures and tensions of modern living. Parents who abuse children are frequently people with personality defects or character disorders. They may be neurotic, emotionally disturbed or mentally ill. The symptoms of their disorganized state are manifested in deviant behavior and bursts of violence or anger directed at other people, including their children.

Many of these parents may themselves have been victims of parental neglect or abuse, and their behavior is a reflection of what they were exposed to as children. Most of them are not capable of providing adequate care for their children without outside help.

What such parents need is help – help and treatment. They need services to guide and counsel them toward accepting their responsibilities as parents – to rebuild their damaged personalities – to give them the strength and stability to successfully live up to parental roles.

But while many parents will respond to skilled services, some parents cannot be helped. Others cannot be helped soon enough to avoid the risk of exposing their children to more abuse. In such cases the protective social service will take action through the juvenile court to remove the child from a dangerous situation. The best interest of the child – his very safety – may dictate removal from the home as an immediate and necessary action. Decisions of this type require mature, experienced judgment, plus skill and training in handling children's problems.

With these philosophical considerations as a background let us examine the legislation enacted to implement them.

LEGISLATIVE ACTION

The grim reality of child abuse and the shocking revelations of research in this area spurred communities into social action. Public concern and recognition of need pressured legislative bodies into giving attention to the problem at a pace with little precedent in recent legislative history.

In the span of four legislative years all 50 states enacted laws seeking reports of injuries inflicted on children. The rush to go on record on behalf of child victims of abuse began with the introduction of 18 bills in 1963. Of that number, 11 achieved passage that year. These were the first such laws anywhere.*

The tempo continued in 1964, a legislative off-year, with 10 additional states passing similar laws. The momentum reached full pitch in 1965 when 26 states were added to the roster of states with reporting laws. Five states – California, Minnesota, Ohio, Oregon and Tennessee – began a second go-round with the 1965 sessions of their legislatures, passing amendments to reporting laws enacted in 1963 or 1964.

Some of the laws achieving passage in the 4-year period were hastily conceived and reflect public indignation against parents who abuse children. Most of them, however, were more thoughtfully prepared. They show awareness of the imperative need for protective social services on behalf of child victims if they are to be truly protected.

The laws are characterized by many differences in form and substance. Some of the differences are minor and may be attributed to the differing administrative or organizational structure in each state. Other differences are more generic and reflect a variance in the philosophy of how to treat the problem of child abuse. This is particularly true in relation to the approaches discussed above.

The laws also contain many areas of common agreement and areas of conformity with suggested legislation and guidelines developed by national agencies promoting mandatory reporting laws.

The degree of conformity, the extent of common agreement, the stated or implied philosophy and the strengths and weaknesses of the 53 enactments (50 states, 3 territories) are reviewed and assessed in the analysis which follows.

STATUS OF REPORTING LEGISLATION

In the sections which follow we have reflected recent changes in the reporting laws of the 50 states. As reported earlier, although these laws are a rather new development, individual state legislatures have developed a passion for tinkering with them. Each legislative session has seen a rash of bills introduced on the subject of child abuse. Most are consigned to the wasteland of bills which fail of passage. Some make the successful transition into law. Eighteen states and the Virgin Islands modified their reporting laws between 1967 and 1970 when the first edition of *Child Abuse Legislation in the 1970's* was published. In the ensuing three years a total of 37 states enacted substantive amendments – 17 of these coming during the 1973 legislative sessions.

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* California was reputed to have an earlier law, but it did not specifically relate to children. The old law required reporting of any injuries inflicted by any person in violation of any Penal law. California enacted its first child abuse reporting law in 1963 and amended it in 1965, 1968, 1971, 1972, and 1973.

Reporting laws are digested and cited in relation to 14 basic elements. To permit full understanding of the laws and the analytical discussion, these elements are defined below.

1. Statement of Purpose

State policy in regard to the subject matter of a specific law is often found in a purpose clause which defines the intent sought to be served by a particular legislative act. In that statement, the legislature goes on record with an expression of the ultimate goals and objectives which it seeks to achieve by the law. If there be ambiguities in the legislative language the purpose clause serves as a guide for interpreting or resolving doubts created by other language.

Review of the 53 laws reveals that 34 states, the District of Columbia, and the Virgin Islands have incorporated a purpose clause in their reporting laws. Thus, 65% of the jurisdictions recognize the strengths which accrue to the law when it contains a statement of purpose and objectives.

After defining the primary goal the legislators elaborate on the statement of purpose by defining the mechanism which they intend to set in motion in response to a report of child abuse.

So, to the primary goal is added language which broadens its scope and application – language which, at the same time, identifies legislative intent in regard to the kind of community resources sought to be marshaled into action on behalf of abused children reported under this act.

2. Age Limits for Reportable Children

There is considerable variation in the upper age limit employed by the states in defining the age of the child coming within the protection of the reporting law. Twenty-six states, the District of Columbia and Guam have set the upper age limit at 18, five states use the age of 17 and eight states have established 16 as the upper age limit. Oregon and the Virgin Islands restrict the protection of the reporting law to children who have not yet attained the age of 15. The California law specifies the age of 12 as the upper limit. Nine states have reporting statutes which do not specify the age of protected children. In lieu of a stated age they employ the terms "child" and "minor," thereby making it necessary to refer to other parts of the statutes in order to determine the age limits.

Two states, Delaware and Washington, have extended coverage of the reporting law to include the mentally retarded, irrespective of age. Nebraska requires a report involving abuse of any "incompetent or disabled person," and Ohio provides protection to "any crippled or otherwise physically or mentally handicapped child under 21 years of age."

Age limits based on juvenile court jurisdictions seem most logical because the court is a resource whose services may have to be invoked on behalf of the child by the protective social services in circumstances of acute risk and hazard.

3. What is Reportable

This is the second important jurisdictional element required to bring a situation within the scope of the law. For a specific case to be reportable the reporting person must have "reason to believe"; "reasonable cause to suspect"; or "have reasonable or just cause to believe" that a child's injuries were inflicted by other than accidental means; or as a result of abuse or neglect. While some of the statutes contain somewhat different language, their meaning is substantially the same.

The effect of this language is that the reporter's diagnosis need not be absolute. He does not have to prove conclusively, even to himself, that the child is a victim of inflicted injury. If the circumstances are such as to cause him to feel doubt about the history given; if he has cause to doubt the truthfulness of the person who tells him about the alleged accidental cause of the injury; or if X-ray or other examinations reveal symptoms and facts inconsistent with the circumstances described, then he has sufficient "reasonable cause to suspect" that the injuries may have been inflicted rather than accidental. This would be enough to satisfy the requirements of the law.

4. Definition of Abuse

Eighteen states have attempted to enlarge upon "reportable conditions" by including a definition of abuse in their reporting laws. The degree of specificity contained in the definitions varies greatly from jurisdiction to jurisdiction. The Colorado, Idaho and Wyoming statutes define abuse in very explicit, medically symptomatic terms. On the other hand, Alaska defines abuse very broadly as "the infliction, by other than accidental means, of physical harm upon the body of a child." Other states, such as Nebraska, also use a broad definition but enumerate specific abusive acts, e.g., leaving a child ". . . unattended in a motor vehicle, if such minor child is six years of age or younger."

Statutes also differ significantly in that some definitions contain elements of intent. The Oregon definition, for example, requires that the injury be "*intentionally or wantonly*" inflicted. Maryland's definition demands that in order to constitute abuse, the injury must be sustained as a result of "cruel or inhumane treatment or as a result of malicious act or acts. . . ."

5. Nature of Report

Reporting legislation is a device for compelling or inducing persons with knowledge of suspected child abuse to report the facts to the agency designated by the law. Consensus favors the concept of mandatory legislation. Logic for this rests on the knowledge that we tend to do that which we must. We are more prone to live up to a responsibility which cannot be evaded. The duty which permits no choice is a duty with which we comply more regularly.

In 1970 when the first study was published, four states had reporting laws which were permissive in nature. The person or persons cited in the law were under no legal obligation to report. Currently, however, in all 50 states, the District of Columbia, Guam and the Virgin Islands the reporting laws are mandatory. These persons enumerated in the law *must report* all situations where they know or suspect that a child has been abused.

Six states (Arkansas, Hawaii, Iowa, New York, Maryland, South Dakota) have included provisions in their statutes which make reporting permissive for persons other than the target professionals enumerated in the mandatory reporting provision. Typical of such language is that contained in the Hawaii law which provides that "any other person who has reason to believe that a minor has had injury inflicted upon him as a result of abuse or neglect *may* report the matter."

Accusatory or Non-accusatory

Twelve states and the Virgin Islands have a clause in their reporting law which requires the reporting source to identify the perpetrator as falling within a class of persons "responsible for care of the child." This requirement arises from phrasing which says in effect that the child sustained injuries inflicted "by a parent or caretaker"; "by a parent, guardian or custodian"; or "by a parent, stepparent, legal guardian, or any other person having custody." Language such as this makes the reporter responsible for identifying the perpetrator of the inflicted injuries as one of the mentioned caretakers.

Should the maker of the report be obliged to identify who injured the child? Does not this requirement constitute a serious block to reporting?

Meeting this obligation places the reporter in an accusatory role. Where the reporting law is housed in the criminal code (in 14 states and the Virgin Islands) the person reporting is in effect asked to make allegations of criminal activity. And where reportable abuse includes only those injuries inflicted intentionally or willfully (in seven states), the reporter is required to make a determination of intent. It is far less demanding upon the reporting source to report only cases where the circumstances are suspicious without the necessity for identifying either *intent* or the *perpetrator*.

6. Who Reports

All but six states designate the medical profession as the principal target group for reporting legislation. Medical practitioners constitute the most logical and responsible group to come in contact with children whose injuries require treatment. They are also the most competent to make the diagnosis of "injury probably due to other than accidental cause."

Many states include other professionals in the group of those who are obliged to report. Thus, teachers, social workers, visiting nurses, school administrators, attorneys, clergymen, law enforcement officers, coroners, medical investigators, psychologists, and administrators of child care facilities are mentioned by at least one or more states.

Five states do not follow the general pattern. These states do not designate a specific target group, but rather impose a legal obligation upon *any person* who has "knowledge" (Tennessee), "reason to believe" (Indiana), "cause to believe" (Texas and Utah), or "cause to suspect" (New Hampshire) that injury has been inflicted.

In addition to the five states discussed above, 17 others supplement the requirements that specified professional target groups report by placing a statutory duty to report on "any other person" who encounters a child who may have sustained an injury by other than accidental means.

Broadening the law's coverage, in terms of who reports, results in putting into legislative mandate the moral obligation of all citizens to come to the aid of neglected, abused and exploited children by invoking in their behalf the protective social services of the community. If we accept the concept that casefinding, in this context, is a universal obligation of all responsible citizens and all community agencies, then translation of that obligation into legislative ukase is truly appropriate.

We believe a combination of the different patterns would result in more accurate casefinding. We must continue to single out special target groups such as medical practitioners and other professionals in contact with children, but adding a phrase like "and any other person having knowledge" would enhance the casefinding potential. The national experience of Child Protective Services documents that a larger proportion of reports come from relatives, neighbors and other nonprofessional sources. Their inclusion would provide for them the protective immunities granted to target professional groups cited in the law.

7. Report – How Made

An overwhelming majority of the states emphasize the importance of urgent action in reporting suspected inflicted injury. Usual language is the phrase, "an immediate oral report shall be made by telephone or otherwise." Another common phrase is "forthwith by telephone or otherwise." Most of the states calling for an immediate oral report have the added requirement that this be followed by a report in writing.

The usual requirement is that the reporter furnish identifying data such as names and addresses of child and parents, the child's age, the nature and extent of the injuries, evidence of prior injuries, and any additional information that might be helpful in establishing the cause of the injuries and the identity of the perpetrator.

8. Report – To Whom

Twenty-three states specify that reports are to be made to a single receiving agency. In seventeen of these states the designated agency is a county or state department of welfare; five have designated a law enforcement agency to receive reports; and in one state all reports are made to the juvenile court. Of the jurisdictions not following one of the above patterns, twenty-one permit the person reporting to notify one of two or more specified agencies, with the remaining states requiring reports to two or more specified agencies.

The designation of the receiving agency is one of the most critical elements of the reporting law. The nature and orientation of the agency first receiving the report will often determine the community's response to child abuse. In a number of states there is a clear inconsistency between the expressed intent of the reporting law and the functional nature of the agency designated to implement the law. A detailed discussion of this point follows in Section III, "Analysis and Comments."

9. Mandate to Receiving Agency

The degree of protection which the community makes available to abused children will depend, in great part, on what the agency designated to receive the report does about that report. The speed with which it acts, how responsibly it provides service and its interpretation of what is expected of it in these cases, all bear directly on this point.

Legislative action could add a measure of control if the law provided direction or guidelines to indicate what type of action is expected and to impose specific responsibilities upon the agency charged with receiving the report. To a greater or lesser extent, 44 states and Guam incorporated a specific mandate to the receiving agency. These mandates carry more explicit direction, require particular action or permit options for discretionary action by the designated agencies.

10. Immunity

An important element of the law is the provision which grants immunity to those reporting under the act. The immunity is against the possibility of criminal or civil action as a consequence of having made the report. The medical profession, a special target group in the law, thinks itself particularly vulnerable to lawsuits without such protection. Thus, inclusion of immunity provides some freedom from fear of retaliation by angry and, frequently, disturbed parents.

All fifty states, the District of Columbia, Guam and the Virgin Islands include an immunity clause in their law.

11. Waivers

Because the medical profession expressed concern over the propriety of divulging confidential matter disclosed to them in the doctor-patient relationship, reporting acts provide a waiver. Thus, a doctor is freed from legal or ethical restrictions against revealing confidential information in 39 states, the District of Columbia, Guam and the Virgin Islands.

There is a like privilege between a husband and wife in many states. Neither may divulge information damaging to the other in any criminal procedure without a release from the spouse against whom the evidence is being given. Many of the reporting laws make the husband-wife privilege inapplicable in child abuse cases because quite frequently the only witnesses are the parents themselves. Explicit waivers of this privilege are found in 31 states, the District of Columbia and the Virgin Islands. In nine more states and in Guam the statutory language is not clear but there is inference to support thinking that this waiver is included. In these states the law grants a waiver of the doctor-patient and "similar" privilege, or it provides that any privilege recognized by law or a professional code of ethics is not applicable in proceedings involving child abuse.

In all but two states it is clear that the privileged status of attorney-client communications is preserved in the absence of an express waiver by the client. Alabama's reporting law, however, provides that "The doctrine of privileged communication shall not be a ground for excluding any evidence regarding a child's injuries or the cause thereof," and Nevada makes inapplicable in abuse cases "all privileges against disclosure recognized by Nevada law." The Alabama and Nevada statutes can conceivably be construed to abrogate the traditional attorney-client privilege, although such an interpretation would raise serious questions relating to the desirability of such clauses, and, perhaps, even their constitutionality.

12. The Penalty Clause

The penalty clause is a provision in the reporting law which makes it a misdemeanor for a person to willfully violate provisions of the act. Failure to report when one of the persons designated in the law has reason to believe that a child may have received inflicted, rather than accidental, injuries is punishable as a misdemeanor in a number of states. The underlying philosophy for the inclusion of a penalty clause is that no action can be mandated by law without also providing a penalty for failure to comply with that legal obligation. It is a device for enforcing the law.

There is a considerable difference of opinion with respect to the value of a penalty clause in a law such as this. A penalty clause is found in the laws of 29 states, Guam and the Virgin Islands.

13. Central Registry

Thirty-three states incorporate into their reporting law a requirement that some governmental unit at state level maintain a register of all reported cases of suspected child abuse. In 30 states the State Department of Social Services is charged with this responsibility. In California the register is maintained by the State Bureau of Criminal Identification and Investigation; in South Carolina the county departments of public welfare maintain the registers; and in Virginia responsibility is given to the Bureau of Vital Statistics, State Department of Health.

These central registries may serve two principal purposes: They may be used to gather data on the incidence and characteristics of abuse and neglect; and they may be utilized as a resource for identifying repeated abuses of the same child or of other children in the same family.

Since several states have changed their laws since the time of this publication, it is suggested that you contact The American Humane Society, Denver Colorado, 80201, for further information on this subject.

CHILD ABUSE: ATTEMPTS TO SOLVE THE PROBLEM BY REPORTING LAWS

By Rowine Hayes Brown, M.D., J.D.*

Although world history is replete with evidence of infanticide, maiming, and other harsh treatment of children throughout the centuries,[1] society has not yet been able to assure protection of its children from malicious acts inflicted by the parents or others in close contact with them. During the last 12 years, physicians, social workers, lawyers and the public have become deeply concerned and aware of the increasing numbers of children who are either being killed or physically and/or mentally damaged, by their parents or those who should be their protectors. In my own experience at Cook County Hospital,[2] I have observed over 500 young children hospitalized because of severe physical abuse. 15% of these children were under 1 year of age; 66% were 3 years of age or less; and approximately 10% died as a result of their injuries.

Growing concern over this problem resulted in the enactment of child abuse reporting laws, the majority of which were modeled after a prototype suggested by the Children's Bureau.[3] The depth of concern in the United States with child abuse is measured by the fact that within a 4 year period, all American states plus the District of Columbia and the Virgin Islands had enacted "Battered Child Reporting Laws". The first such state statute was passed in California in 1963 and the last in Hawaii in 1967.[4]

In this article I will attempt to describe and analyze these statutes. The primary purpose of these reporting laws is to bring into the open and to identify children who are being abused, so that they may receive required therapy and protection.[5] A secondary purpose is that mandatory reporting will bring to light the true incidence of abuse and demonstrate the magnitude of the problem.[6] Reporting statutes would be ineffective unless reported children are, in fact, protected from further injury and offered a chance of a brighter life with a foster family, should remaining at home prove impossible or unsafe.

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Women Lawyer's Journal, v. 60, Spring 1974.

Child protection and welfare must be provided by agencies trained in such disciplines, to whom abused children may be referred subsequent to their being reported.

Mandatory or Permissive Reporting

Statutes making reporting of child abuse incidents mandatory exist in all but six States. Permissive reporting is suggested in Alaska, Missouri, New Mexico, North Carolina, Texas and Washington, but not required.

Who is Required to Report

The model statute suggested by the U.S. Children's Bureau places the duty to report primarily on physicians and other medical practitioners due to the fact that children are brought to physicians for treatment of their injuries and the doctor could be the first to suspect the diagnosis of child abuse. A physician also would better know the truth about injuries a child received, rather than having to accept the distorted story of the facts explained by the mother or other historian. The classification of persons charged with reporting was limited due to the fact that an immunity clause was sought by the majority of states in their child abuse laws. It was felt that the larger the scope of the reporting group requesting immunity, the smaller the chance that the legislature would enact an immunity clause to cover all of them. Immunity does not deprive one of his constitutional rights to sue, but precludes monetary recovery.

There are three states[7] whose law simply states that "any person" may file a report. There are 47 states where physicians and other specified persons are to file reports, and in 23 of these states[8] only physicians are to report. Illinois, which required reporting only by physicians, amended its Child Abuse Act[9] in 1973 to include reporting by others. 20 states[10] include nurses; 12[11] include social workers; 12[12] include teachers or school principals. Other states have added laboratory technicians,[13] pharmacists,[14] dentists,[15] law enforcement officers,[16] Christian Science practitioners,[17] attorneys,[18] clergymen,[19] coroners,[20] undertakers[21] and embalmers.[22]

What Injuries Are to be Reported

Although a physician on preliminary examination is unable to determine who inflicted injuries upon a child, he is usually able to determine what injuries were caused other than by an unavoidable accident. The physician will be suspicious of child abuse upon perceiving:[23]

1. any very young child with any severe injury,
2. any child with multiple injuries

in existence at the same time,
3. any child with repetitive trauma,
4. any child with many scars, or
5. any child whose injuries could not be caused in the manner stated in the history.

As suggested by the Children's Bureau,[24] the majority of child abuse statutes require reporting of "serious physical injury or injuries inflicted upon him other than by accidental means by a parent or other person responsible for his care". The majority of statutes do not define the terms "abuse" or "neglect" and those that do (Maryland and Oregon) are vague. A few states (New York, Ohio, Tennessee, Illinois) direct the reporting of an injury caused by "neglect" which is again a situation difficult to interpret.

None of the original child abuse reporting laws required reporting of a dead child, except in Arkansas where coroners report and in Tennessee where undertakers and embalmers report. Illinois has amended its child abuse act to include dead children. Following the reported death of a child, an investigation of the family circumstances may save his siblings from a similar fate.

"Malnutrition" must be reported in Illinois, New Mexico, and South Dakota. Often children who are physically abused are generally neglected and may be improperly fed, or even starved.

To Whom Reports Are Made

The method of handling cases will depend somewhat upon the agency receiving the report under the statute, usually either: Police, the prosecutor, Department of Social Welfare, or the Juvenile Court. The original plan to report to the police was based upon the fact these departments are always open and that their help is always available. Many states still require reporting to police.[25] However, such action stresses punitive aspects of abuse. As a result, the Children's Bureau and the majority of workers in child abuse today favor reporting to a public child welfare agency,[26] when such agency is authorized to provide child protective services. Some states allow reporting to a welfare agency in addition to police.[27] In only 4 states, the primary responsibility is that of the welfare agency. In others, reports to be made to the Juvenile Court,[28] 4 to the local prosecutor,[29] one to a peace officer,[30] one to the medical examiner.[31]

The investigation of the home circumstances and recommendations for the solution of the particular child abuse situation are the important elements for determination. These, as a rule, are performed more competently and with more understanding by a social service or welfare agency.

Central Registries

The maintenance of a state-wide registry is an important part of the child abuse program.[32] Physicians and social service workers desire such registries in order to more rapidly determine if the child with which they are now concerned has in fact been previously reported as a battered child. Such a registry, is of additional value for statistical studies and research. In 4 states, central registries were established by the statute.[33] In Illinois, the central registry is located in the main offices of the Department of Children and Family Services,[34] the welfare agency to whom reports must be made, and their data is available only to their own personnel. Practicing physicians derive little or no benefit from it. In some jurisdictions, registries have been created by social agencies and others on a voluntary basis.[35] The existence of a central registry used for anything but statistical purposes has raised sensitive issues of privacy (Col. Law Review p. 31). Diligence and caution should be exercised so that cases in which abuse was not found to have occurred can be removed from the registry.

Immunity From Liability For Reporting

Physicians have heretofore feared legal liability resulting from reporting cases of suspected child abuse. They particularly fear that a finding of child abuse might not be established following their report. In an attempt to reduce that fear, statutory enactments have been passed to the effect that reporting physicians are now clothed with statutory immunity from civil and/or criminal suit provided they report in good faith and/or participate in the subsequent judicial proceeding resulting from such reporting.[36] In only 3 states[37] immunity clauses are omitted from the child abuse statutes.

In 30 of our states,[38] the statutes relate that the physician-patient privilege is not a bar to testimony on the basis of privileged communication and therefore in these jurisdictions, physicians would be expected to disclose in a forum, facts learned in the course of their physician-patient relationship. Under these circumstances, they would not be considered as betraying professional secrets to the detriment of their patient.

Liability For Failure to Report

A child or parent is unlikely to prevail in his suit against a physician, who has in good faith reported a case of child abuse involving either or both to the authorities. Many of the reporting statutes carry a criminal penalty for failure to report. Such penalties include fines up to $500[39] and/or incarceration for as long as one year.[40]

If a physician fails to report his findings of child abuse when he has a statutory duty to do so he may be liable to prosecution and even incur civil liability. In most states, violation of a criminal statute is "negligence per se". If the physician fails to carry out his mandatory duty to report he has precluded the intervention of the child protective agencies to prevent further injury to the child and such failure could result in a civil cause of action against him in favor of infants who suffer abuse.[41]

Results of the Legislation

After the announcement of the mandatory reporting laws, numerous reports of child abuse were received throughout the United States. The number of reports were far in excess of those anticipated. As a result, agencies were swamped with reports and were handicapped by inadequate personnel. There were lags in "intake", records, investigations, preparing and getting cases to court, etc. Publicity through symposia, panels, speeches, press and professional literature focused on this problem. Many children who were illegally abused were not reported and many who were not so abused, were reported.

Child abuse continues to be a major social problem today affecting our young children. Changes of the social milieu could decrease its incidence, but until that Utopia arrives, we must provide better child protective services. Our first line of attack should be the child protective agencies, with juvenile courts as a backup facility. Overcrowded juvenile court calendars should have their work loads reduced so that the child who comes to court for deliberation concerning his future, will not have his life's course decided in a far too brief hearing.

Is Further Legislation Needed?

Many people feel child abuse laws should become more rigid. Some feel police should be involved at the onset and that more serious penalties should be enacted to punish physicians who fail to report cases. In my opinion, the problem cannot be "legislated out of existence".[42] If child welfare agencies are to be given more responsibility concerning these cases, their authority and responsibilities should be spelled out in detail. Adequate appropriations must be included in state budgets to fund the reporting plan and to provide for preventative and rehabilitative services. Implementation of good laws often depends on appropriations, and often fails due to the lack thereof.

Protective services for children are often inadequate and governmental appropriations are negligible or non-existent (only Illinois and Massachusetts have appropriated anything).[43] Rehabilitation and therapeutic services for the abusers are often inadequate or nonexistent; foster homes for temporary child placement have at times been no better than the homes in which the original abuse occurred; decisions concerning the child and his future are often made in court without any legal representation on behalf of the child; physicians are still reluctant to appear in court to testify in the child's behalf.

Strict adherence to existing laws, lawyers and officials involved diligently attending to their duties, adequate funding for agencies and services, plus the "watch dog" attitudes of dedicated people and the press could clear up many of the above recited deficiencies.

Con

1. R.C. Helfer & C.H. Kempe, The Battered Child 8 (1968). Infanticide was practiced by the ancient Egyptians, Greeks, and Romans.
2. These children were hospitalized at the Cook County Children's Hospital between July 1, 1965, and June 30, 1973.
3. In 1962 the Children's Bureau of the Department of Health, Education and Welfare, conducted a symposium on this problem in Washington, D.C., and suggested a model statute.
4. For a listing of such statutes, see Paulsen Child Abuse Reporting Laws: The Shape of the Legislation, Columbia Law Review, Vol. 67, No. 1, January 1967, p. 3.
5. Brown, R.H., Fox, E.S., Hubbard, E.L. Medical and Legal Aspects of the Battered Child Syndrome, Chicago-Kent Law Review, Vol. 50, No. 1, (1973), p. 62.
6. Brown, R.H., The Battered Baby, 70 Chicago Medicine, No. 6 (1973).
7. Nebraska, Tennessee, Utah.
8. Arizona, California, Colorado, Connecticut, Delaware, Florida, Idaho, Louisiana, Maine, Maryland, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey, Ohio, Pennsylvania, Rhode Island, South Carolina, Texas, Vermont, Washington, Wisconsin.
9. Illinois H.B. 32, 78th General Assembly, 1st Session (1973).
10. Alabama, Alaska, Arkansas, Georgia, Iowa, Kansas, Maryland, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Virginia, Wisconsin, Wyoming.
11. Alabama, Alaska, Georgia, Kansas, Maryland, Montana, Nevada, New Mexico, North Carolina, Ohio, West Virginia, Wisconsin.
12. Alabama, Alaska, California, Illinois, Maryland, Montana, Nevada, New Mexico, North Carolina, Ohio, West Virginia, Wisconsin.
13. Indiana, Wyoming.
14. Alabama, Arkansas, Minnesota, Pennsylvania, Wyoming.
15. Illinois, Iowa, Mississippi, Nevada, New York, Oklahoma, South Dakota.
16. South Dakota
17. Illinois
18. Nevada
19. New Mexico and Nevada
20. Arkansas
21. Tennessee
22. Tennessee
23. See note 5 supra (p. 48).
24. Children's Bureau, U.S. Dept. of Health, Education and Welfare: The Abused Child - Principles and Suggested Language for Legislation and Reporting of the Physically Abused Child (1963).
25. Arizona, Arkansas, California, Colorado, Kentucky, Louisiana, Missouri, and Virginia.
26. Reports are made primarily to a child welfare agency in Idaho, Illinois, Massachusetts, New York, North Carolina, Vermont, Wyoming.
27. Alabama, Connecticut, Indiana, Maine, Michigan, Oklahoma, Pennsylvania, South Carolina, Texas, Utah, Wisconsin.
28. Delaware, Florida, Kansas, Mississippi, South Dakota, Tennessee, Washington.
29. Montana, Nebraska, New Jersey, West Virginia.
30. Ohio
31. Oregon
32. See note 4 supra (p. 24).
33. California, Illinois, Maryland, Virginia
34. The Department of Children & Family Services is an agency of the State of Illinois. It is concerned with social and welfare problems relevant to children. It is the agency to whom reports of child abuse must be made in Illinois.
35. In states: Colorado, Florida, North Dakota, Utah; and in cities: Cincinnati, Milwaukee, New York City.
36. See note 5, supra (p. 47)
37. Minnesota, Oregon, Wisconsin.
38. Alabama, Alaska, Arizona, Arkansas, California, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, [illegible], Missouri, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah, Virginia, Washington, Wisconsin, Wyoming.
39. Alabama $500, Arizona $100, Arkansas $500, Kentucky $10-$100, Louisiana $100, Missouri $100, Nebraska $100, New Hampshire $500, Pennsylvania $300, South Dakota $100, Utah $29, Wisconsin $100, Virgin Islands $500.
40. Alabama 6 mos., Arizona 10 days, Arkansas 6 mos., Louisiana 10 days, Missouri 6 mos., Pennsylvania 90 days, South Dakota 30 days, Wisconsin 6 mos., and Virgin Islands 1 year.
41. See note 5 supra (p. 63, Footnote 122).
42. See note 6 supra.
43. When their initial child abuse statutes were enacted Illinois appropriated $50,000 and Massachusetts $100,000.

C. Treatment

Staff of a child abuse program in a Philadelphia hospital worked with parents in their own homes to help them develop greater competence as adults and as parents. This article describes the use of social learning theory, with some techniques of behavior therapy, as the basis for treatment.

Treatment for child abusers

by James J. Tracy
and Elizabeth H. Clark

For eleven years public attention has been focused on child abuse. In writing of the "battered child syndrome," Helfer and Kempe helped define the problem.[1] Explanatory theories and treatment programs for child abuse are emerging rapidly at the same time as adequate research is falling behind. Although reference is frequently made to emotional and psychological abuse, *child abuse* in this article refers to children who show evidence of physical injury or physical neglect by the parent.

The bulk of professional opinion, as summarized by Spinetta and Rigler, maintains that psychological factors within the parents are the primary causes of child abuse.[2] Because psychodynamic theorists have generated them, most theories of child abuse are concerned with the effects of mental and emotional forces that developed in early childhood. In *Helping the Battered Child and His Family*, Kempe and Helfer summarized several treatment strategies.[3] Participants in treatment programs too often end up discussing better relations between and within professional agencies without addressing themselves to the abused child or the adults who are abusing him. Hence, both professional opinion and treatment programs seem limited.

Social learning theory is so named because of its concern with society's effect on the individual. The theory attempts to identify the psychological processes and techniques used to help individuals participate socially. Bandura and Walters outlined social learning theory in a developmental context,[4] and psychologists, psychiatrists, and social workers have demonstrated how to apply learning theory to their fields.[5]

The child abuse project at Presbyterian-University of Pennsylvania Medical Center chose social learning theory as the basis for its treatment model.[6] This was done because the project was designed to change behavior through the use of social as opposed to primary reinforcement. The theory involved an identification of behavioral goals, followed by specific techniques of achieving them and by constant evaluation. Also the model seemed well suited to deal [illegible]

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with environmental factors that prevent a person from developing competence as a parent and an adult. The choice was appropriate for another reason. The project consultants, realizing the negative attitude many social agencies hold toward learning theory and behavior modification, was prompted to use less provocative words.

The program strives to move beyond diagnosis and etiological concerns to help abusive adults achieve competence in their roles as parents. In contrast to many popular theories that make assumptions about the pathology of abusing adults, a social learning analysis of child abuse makes the following observations:

- Abusive adults have few skills to help them function competently as adults. They gain little satisfaction from their role as parents.
- Abusive adults are frequently ignorant of child development. They expect behavior too advanced for young children.
- They control their children's behavior almost exclusively through punishment, because they lack knowledge of alternative means of controlling them.
- Abusive adults are more likely to respond to therapeutic personnel who are of similar socioeconomic and racial background and who will work with them in their own homes.
- Therapeutic personnel, both professional and paraprofessional, frequently overestimate the competence of abusive adults.

These assumptions were made after working with abusive adults in their own homes over a period of one year.

CHILD ABUSE PROJECT

The project described in this article took place in the area surrounding the Presbyterian–University of Pennsylvania Medical Center. Because this is a predominantly black neighborhood, the decision was made to have blacks work in the project.

Three full-time members of the social service department are available for suspected cases of child abuse. At present one of these social workers is black and lives in the community surrounding the hospital. The coordinator of the outreach program is a black registered nurse who is familiar with the community served by the hospital. All four of the family health workers are black women ranging in age from 35 to 50 who live in the nearby community. They were selected for their ability to listen sensitively in an interview and to respond in simple language. No specific educational level or prior training was required.

Outline of the program. The first step in the child abuse project is to identify the cause of injury. All children entering the emergency ward are screened. If the attending physician has any suspicion of child abuse, he is instructed to alert the staff pediatrician and the social service department. Two members of the social service department are on voluntary twenty-four-hour call, seven days a week. If the examination or evaluation by the staff pediatrician or social worker supports the suspicion of child abuse, the child is hospitalized, regardless of the extent of his injuries. Further assessment of the case continues for the next few days. If the suspicion of child abuse remains, a legal form is completed and sent to the city's department of public welfare with a statement that the child abuse project will be providing this family with continuing services in the home.

The second step in the child abuse project is to conduct a precise behavioral analysis of the parent's techniques of child management. The authors observed that the abusing adult was most often a single mother. The initial analysis is based primarily on a detailed interview. The staff member makes no attempt to get a description of the specific abuse, but rather asks the parent to discuss general punishment or techniques of controlling the child. From the everyday pattern it is not difficult to extrapolate the abusive behavior that caused the child's hospitalization. Often it becomes clear that punishment is the adult's only way of controlling the child. Subsequent interviews and observation identify the times and places when an adult is likely to be easily upset and short-tempered. Special attention is directed to the child's actions and to the adult's thoughts and feelings immediately before a confrontation with the child. The interview also focuses on the immediate consequences or what happened directly after the abusive action. What did the child do? What did other adults do? The parent is asked when the child is easier to cope with and when he is likely to trigger punishment. The hospital social worker conducts these assessment interviews with the goal of completing an analysis of abusive behavior—its antecedents and consequences.

The third step in the child abuse project is to decide whether the child can be returned to the family if the outreach program provides continued assistance. In all cases so far, there has been sufficient evidence to allow the child to return home. No parent has refused the treatment offered.

The fourth step involves formulating plans and goals for treatment. These are discussed by the social worker and the parent and are based on the behavioral analysis the social worker has prepared.

The fifth step is to introduce the family to the outreach staff, usually at the time the child is discharged from the hospital. Using the behavioral analysis and treatment plans as a starting point, the family health worker begins to work with the child's parents within a few days of his release from the hospital.

TREATMENT

If analysis reveals that severe turmoil at bedtime is likely to illicit strong punishment, specific plans can be developed by the family health worker and the parent. Together they will discuss the environmental obstacles that block a peaceful bedtime. For example, it may well be that the child has no bed—only a drawer or a bed he must share. If easing the stress at bedtime is a high priority, the worker can help the parent get a bed or can rearrange the sleeping facilities to lessen the aggravation. In this manner she can help the parent gain beginning competence. Too, it may be that the turmoil at bedtime is increased by constant verbal punishment. In this case, the worker can demonstrate the technique of "catching the child being good," a technique that involves teaching the parent to reinforce positively the child's good behavior. Frequently, the adult has developed the habit of ignoring good behavior and attending only to bad behavior.

The specific plans attempt to move the adult into a role of competent parenthood. The parent is encouraged to contribute ideas and to take part in making plans. As small gains are made, the family health worker reinforces them by explicitly pointing out the ways in which the parent was successful. The goal of these consultations is to demonstrate informally positive techniques of child management.

In working with a family, the worker is encouraged and helped to reformulate the behavioral analysis and plans for treatment. These revisions often serve as a valuable learning experience for the staff, including the social workers and medical personnel who identified the problem.

The family health worker frequently becomes an advocate for the family in housing projects or welfare offices. She tries, however, to avoid reinforcing dependent behavior. Instead, she serves as a role model for appropriate assertive behavior. The role of the family health worker is, then, an active one. She is not intended to be a lecturer, but someone who can articulate and demonstrate effective principles and techniques.

Continuity of service. An important goal of the child abuse project is to establish continuity between the child's hospitalization and the treatment within the family. Every precaution must be taken to insure that parents understand the connection between the treatment given in the hospital and at home. From previous experience it was found that partial or redundant interviews conducted by a variety of professionals only confuse the parents. Consequently, the physician and social worker are the only professionals to interview parents while the child is hospitalized. Only after the child is discharged does the social worker introduce the coordinator of the outreach program and the family health worker assigned to the case.

One specific objective in achieving continuity in the delivery of service was to teach all staff a common language for describing behavior, formulating treatment, and communicating with one another. A psychological consultant conducted two ninety-minute training sessions a week—one for the hospital staff and the other for the family health workers. The coordinator of the outreach program attended both sessions. After the first six weeks of the program the consultant conducted bimonthly sessions based on prepared materials and specific cases. The material was designed to teach the assessment of behavior through interviews and observation. Abusive behavior was defined together with its antecedents and consequences. Because the parent and child are caught in a reciprocal system, both the parent's abusive behavior and the child's actions that precipitated it must be analyzed carefully.

Evaluation. A high priority in the project is the development of objective instruments to evaluate behavioral change. The social learning model attempts to define specific behavior related to child abuse, and much of the data necessary in evaluating social change is provided by the analysis of behavior. Specific behavior is monitored by the use of frequency counts, which are usually charted on a weekly basis. Because these are based on the limited observation of family health workers or on the parents' verbal reports, additional evaluative procedures are necessary.

Several pediatricians involved in treating abused children constructed a form designed to assess and quantify the physical symptoms of a child they suspect of being abused. The "Trauma X" form, which is currently used by three Philadelphia hospitals, is the last of three such efforts. The attending physician fills out this form for any child suffering from unexplained trauma. The pediatrician completes it during the frequent interviews at the clinic after the child is discharged. This permits objective evaluation of the possibility of a recurrence of the abusive behavior. The coordinator of the outreach program can also add to the form if she visits the home.

The development of specific instruments of evaluation may allow direct comparison of different approaches to the treatment of child abuse. In this way empirical research can directly address the questions previously answered by theoretical speculation and clinical vignettes.

PROBLEMS AND LIMITATIONS

A recurring problem is staff discomfort created by accountability—in this case responsibility for a clear report of the problem behavior, the treatment and any progress made. Because the project employs the social learning model, the staff is continually confronted with the specifics of accountability.

An anticipated problem was the use by staff members (particularly the professional staff) of vague terminology in their descriptions. References to "a character-disordered" mother or to "hypothetical etiological processes" have decreased as the staff became familiar with terms that describe specific behaviors.

A related problem is the stereotype many professionals hold of theories of learning and behavior therapy. In the beginning this stereotype prevented a close examination of the social learning model, but gradually it has given way to a more inquiring view. Humanistic concern for the client's feelings, for example, appears compatible with the model and is dealt with explicitly. In fact, one social worker remarked that through the learning model she uncovered several middle-class values that had previously masqueraded as objective criteria.

The present pilot project needs to provide additional time for consultation. In the beginning, two full days each month were allowed for this. Although the consultant must ultimately teach skills that will help the hospital staff to function independently, more extensive consultation is needed during the initial phases. At present, all consultation and evaluation have been funded through private donations or given without cost. The present project has been more successful in informal than in formal evaluation.

The child abuse project hopes to provide a model for delivering services that is flexible enough to be applied to areas other than child abuse. High-risk surgical patients, for example, need systematic help after they are discharged. Already the social learning model has been applied to elderly and terminally ill patients.

Although the project is making progress toward the ideals of a social learning model, problems and limitations are still evident. Future goals include attaining more comprehensive quantifiable data on each case, extending the model to problem behaviors other than child abuse, and comparing research with other treatment modalities.

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6. This project is supported by the Haas Community Fund of Philadelphia and consultation is provided by private donations.

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Child Abuse and Neglect Concerns SRS Multi-Efforts

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The Social and Rehabilitation Service (SRS) has six objectives involving $400,000, as a part of its contribution to the Child Abuse and Neglect Intradepartmental Committee appointed by Secretary Weinberger. In addition, SRS has contributed $500,000 for joint demonstration projects.

The six SRS objectives include a reconnaissance of information from State and local welfare departments, research on early warning signals, development of a system to evaluate effectiveness of abuse and neglect services, development of service guides, a "state of the art" study on child neglect, and use of Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) to identify abuse and neglect in early stages.

The demonstration projects are directed toward new and innovative approaches, particularly as they relate to integrated and coordinated delivery of communitywide services to abused and neglected children and their families.

Overall Intradepartmental Effort

The protection of children is largely a State and local responsibility, carried out through a variety of statutory provisions, including criminal law, juvenile court acts, protective services legislation, and child abuse and neglect reporting laws. Federal moneys are available under title IV-A and B of the Social Security Act, largely on a matching basis with State and local expenditures.

The DHEW Intradepartmental Committee was appointed to identify federal efforts which would help State and local agencies find better approaches for dealing with child abuse and neglect. The Secretary directed the Office of Human Development (HD), through the Office of Child Development (OCD), to take the lead in examining the problem and to develop a departmental plan to coordinate action. The agencies involved are the Office of Child Development, Social and Rehabilitation Service, Office of Education, Office of Public Affairs, and the health agencies of the Department.

Secretary Weinberger further instructed DHEW agencies to earmark $4 million of research and demonstration funds in Fiscal Year 1974 for new activities focused on the problem of child abuse and neglect. The $900,000, plus staff resources identified above, is SRS' contribution to this overall effort. In addition to participation in the work of the Intradepartmental Committee, SRS has designated training in child abuse and neglect services as one of the national priorities within the 1974 child welfare training program.

Specific SRS Activity

As a part of our support for the Secretary's Committee efforts, SRS has consistently provided advice and guidance and directed the following:

■ *Child Abuse and Neglect Services Demonstration Project.* SRS has contributed $500,000, along with $900,000 from the Office of Child Development, to fund 11 demonstration projects in eight regions. The money will be used to develop new and innovative approaches aimed at public awareness of the problem; educate the public in the detection, prevention, protection, and care of the abused or neglected child and his family; identify behavior patterns that suggest the potential for abuse or neglect; and help develop an integrated and coordinated approach to the delivery of essential services to children and their parents or caretakers. The demonstration projects are anticipated to be funded for 3 years.

■ *Reconnaissance of Selected State and local Welfare Departments on Abuse and Neglect Services.* A survey was conducted in 10 State and 30 local welfare departments in November and December 1973. This study asked for information on major problems in providing services to abused and neglected children and their families, legal requirements and processes, program administration, program description, community support, and the Department's view of the federal role.

The information secured in the survey of services will have several uses. At the federal level it will help in looking at program administration, in determining the major problems departments of social services, State and local, are facing in the provision of these services, and will be helpful in the development of guides for service delivery systems. It will also provide useful information to the Regional Offices in work with the States.

■ *Research Project on Early Warning Signals of Child Abuse and Ne-*

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glect. Because much abuse and neglect can be prevented or reduced by early detection and services, a 3-year research project is looking into early warning signals which indicate a need for intervention. The project also will test the effectiveness of appropriate services to families identified by early warning signals.

- *"State of the Art" Study on Child Neglect.* A second research project has been funded to produce a "State of the Art" study on child neglect which will analyze and synthesize research and demonstration findings and the experience of experts. This will supplement the Office of Child Development's "State of the Art" study on child abuse.
- *Evaluation System for Measuring Cost-Effectiveness of Protective Services.* Program analysis of protective services will be used to develop an evaluation system to measure the results of protective services. As a part of the analysis, a review will be made of the survey, which was recently completed in 10 States and 30 local departments of social services. Preliminary results indicate that agencies want and need to develop better methods of evaluation in order to plan and provide appropriate services more effectively. The evaluation system developed in this project will be tested in various sites and transmitted to State and local governments for their use.
- *Use of Early and Periodic Screening; Diagnosis, and Treatment (EPSDT) to Recognize and Treat Child Abuse and Neglect.* The EPSDT program will be utilized to recognize and treat child abuse and neglect in various ways. One will be the development, in collaboration with the American Academy of Pediatrics, of material to be used in a manual of guidelines for use in EPSDT.
- *Guides for Model Delivery Systems.* As the final project, SRS plans to develop guides to assist State and local social service agencies to improve their administration and delivery of services, based on some in-depth analyses of exemplary local programs.

Other HEW Agency Activities

Other agency activities within HEW interrelate with those of SRS. The more prominent of the agency efforts are summarized below.

Office of Child Development (OCD). In addition to OCD's efforts on the 11 demonstration projects, OCD will develop and utilize a survey instrument to review local public and voluntary child protective service programs. This should lead to developing program models for demonstration in fiscal year 1975; testing the feasibility of a national clearinghouse; awarding a grant to establish and determine the effectiveness of self-help groups; providing informational materials and support to Head Start programs and experimental projects to include an emphasis on identification; and awarding a grant for the revision of the model Child Abuse and Neglect Reporting Law.

The Office of Education is developing a model for training teachers to identify abused and neglected children, work with other community resources to alleviate the problem, and develop the skills necessary to aid abused and neglected children overcome emotional trauma.

The Office of Public Affairs is providing public service materials to inform and educate the American public about the Department's priority efforts.

The Health Agencies of the Department are involved in the following subobjectives: developing, publishing, and issuing guidelines to 1,500 Bureau of Child Health Services-funded projects and their affiliated backup hospitals for organizing the identification and management of child abuse and neglect in existing health service delivery settings; funding various research projects concerned with the biomedical and mental health aspects of child abuse and neglect; taking the lead in evaluating, jointly with SRS and OCD, the effectiveness of the multidisciplinary demonstration projects; funding research projects that are related to various existing systems of health care delivery and management of child abuse cases in health settings and, through cooperative arrangements with other agencies, testing various mixes of services and the effectiveness of such services.

This Intradepartmental Committee effort has been one of the more successful examples of HEW agencies working together to accomplish a coordinated set of objectives. SRS' commitment to making this effort work has been substantial. SRS continues to work through the Committee to encourage State and local agencies to better overcome circumstances leading to the abuse and neglect of children.

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Bert Shanas

CHILD ABUSE: A KILLER TEACHERS CAN HELP CONTROL

The epidemic is so widespread that every state has, in the past decade, passed or updated laws that require the reporting of child abuse cases. Last year the national Child Abuse Prevention Act was signed into law.

Maryland - Donna S., a 9-year-old fourth-grade student at Damascus Elementary School, arrives at the hospital dead. Examination of her body reveals burns, bruises, and scars inflicted over a long period of time. Donna's mother is held for premeditated murder and torture.

New York - Richard K., a 14-year-old junior high school student in the Bronx, shows up at school with multiple welts on both arms, swollen wrists, and puncture wounds on his legs and buttocks. He is quiet, shy, and withdrawn. When questioned by school authorities, he admits his father has been beating him.

California - A 13-year-old Los Angeles youngster is forced into incestuous relationships with her father. She tries to take her own life on three occasions by overdosing medication, by strangling herself, and by leaping from a school window.

Ugly and revolting as they may seem, the cases cited above are far from unusual. In fact, they are typical of the thousands of cases each year with which teachers come in contact. Child abuse is a "disease" believed to be the largest killer of children in the United States today.

Sixty thousand cases were reported in the nation last year. Some authorities estimate that there are a minimum of 25 actual cases for every one reported. Two children per day are known to be dying from child abuse – more than seven hundred deaths every year.

According to the best estimates, some ten thousand children are severely battered each year; 50,000 to 75,000 are sexually abused; 100,000 are "emotionally neglected"; and another 100,000 are physically, morally, or educationally neglected.

Child abuse is so widespread that within the past 10 years every state in the union has either passed or updated laws that require the reporting of abuse or suspected abuse cases. Twenty-four states specifically require school personnel to report cases. Yet it is an out-of-control epidemic. Nobody knows for sure how many cases continue to go unreported.

"The variation of these [reporting] laws doesn't matter," says Minnesota Senator Walter F. Mondale, who sponsored the $60 million national Child Abuse Prevention Act signed into law early last year. "What matters is that we have seen they don't work. Child abuse continues to go undetected and untreated in case after case."

And though it may sound cruel, thousands of teachers across the country – people who have dedicated themselves to providing for the welfare of children – are contributing to the injury and death statistics by failing to report cases and refusing to get involved in the problem.

Physical abuse and neglect of children at the hands of their own parents is certainly not a new development; one might say it is steeped in tradition. "Spare the rod and spoil the child," advises the Old Testament. "She gave them some broth without any bread/ And whipped them all soundly and sent them to bed," says the nursery rhyme about the fabled woman who lived in a shoe.

The older generation, at least, has read Charles Dickens's accounts of the horrors of growing up in an industrial society; in history lessons we learned that American children received much the same treatment in our own factory systems and turn-of-the-century sweatshops.

The first court case involving child abuse in the United States arose exactly a century ago in New York City, when little Mary Ellen, who was being starved and beaten repeatedly, was unchained from her bed. She was given safety outside her home after church officials called the case to the attention of the Society for the Prevention of Cruelty to Animals. It was after that case that some "conscientious" citizens thought maybe there should be a similar society for children. And so the Society for the Prevention of Cruelty to Children was founded.

But child abuse remained something most folks preferred not to talk about, and it was only 10 years ago that we began to read shocking newspaper accounts of children who are dropped in tubs of boiling water, whose hands are held over flames, and who are beaten beyond recognition for no apparent reason.

For most of those 10 years, the focus was on abuse of the younger child, and it wasn't until fairly recently that authorities began emphasizing that part of the problem is caused by the un-

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willingness of teachers and school officials to get involved. This despite the fact that at least one national study, conducted in 1967, found that half of a sample of some six thousand abused children were over six, or of school age.

"The teacher may well be the first line of defense for the child against child abuse," says Dr. Vincent J. Fontana, medical director and pediatrician-in-chief, New York Foundling Hospital, and chairman, New York City Task Force on Child Abuse and Neglect. He points out that some families (especially middle-income parents) can hide the problem by finding private doctors willing to break the law and hide suspected cases. There isn't even any assurance that poorer youngsters will get to public clinics, which are more likely to report the problem.

But because of the nation's compulsory education laws, few youngsters escape school these days. Teachers may just be the fail-safe method for ensuring that child abuse cases are reported – at least those cases involving school-age children.

Unfortunately, however, large numbers of teachers are still failing to meet this responsibility, and there are several reasons. High on the list is a personal fear of getting involved – a fear that certainly is not unfounded. There have been many instances of parents striking out physically against teachers who have reported child abuse cases. In one California case, a parent actually stabbed a teacher who reported her child as a suspected abuse victim.

School systems more attuned to the problem have alleviated that danger somewhat by making the building principal or another administrator solely responsible for reporting suspected cases. That is, the teacher reports the case, but the same principal's name always goes on the reporting form.

Michigan's Wayne-Westland School District has a reporting policy that outlines specific procedures for reporting, including notification of school officials, the hospital, and the abusive parent. It also tells teachers how to ensure that the child is examined as quickly as possible.

New York City's system makes teachers who fail to report suspected cases subject to a Class A misdemeanor, as well as "civilly liable for the damages caused by such failure." Teachers are actually encouraged to photograph suspected abuse and neglect victims, and educators who make reports in good faith are granted legal immunity. In 1971, 966 New York cases were reported by teachers. In 1973 the number jumped to 2,120. At the end of the first six months of 1974, New York teachers had already reported 2,666 suspected cases – and most cases were still going unreported.

Many teachers who want to report suspected cases run into problems with their own principals and school administrators, who seek to "protect the image" of the school by sticking their head in the sand when such problems arise. At least one county school system in California, realizing what was happening, has mandated its teachers and school nurses to report suspected child abuse cases even when their principals instruct them not to do so.

In other school systems throughout the country, there is simply a lack of procedures for handling the child abuse problem. Mrs. Kay Drews, a former child abuse coordinator at the University of Colorado Medical Center, writing in *Helping the Battered Child and His Family*, told of a survey in which questionnaires about child abuse reporting procedures were mailed to half of the nation's school districts with enrollments of over 10,000 students. Responses were received from 34% of the districts. When asked if they had a standard operating procedure to follow in reporting suspected abuse cases, 49% of the administrators answered in the affirmative, but only 24% of the principals, teachers, and nurses said they knew of such a procedure.

What the study implied, of course, was that high-level administrators who have little direct contact with children were not making practitioners aware of the reporting methods.

"It is not enough to concentrate just on the academics," warns Dr. Fontana. "A teacher can do a great deal just by being human. Sure, there are risks involved in reporting child abuse cases; but the risks are much greater if the teacher fails to report a case she suspects."

It is the teacher's responsibility, whether or not the principal and school system are willing to help, to learn about child abuse, and to be equipped to spot potential cases.

The definition of child abuse varies from place to place. Severely battered children are often easy to spot because the signs are there – repeated bruises and welts a teacher can distinguish from injuries resulting from scraps with other pupils. Then there are the classic neglect cases: students coming to school dirty, hungry, and poorly clothed. Other children suffer from more subtle kinds of emotional abuse. A child whose parent is constantly drilling into his mind the fact that he is unwanted suffers a form of abuse that may ultimately be at least as serious as battering and neglect.

Child abuse and neglect are not always clear-cut and easy to detect, of course. It takes sensitivity, clear thinking, and good training. It is probably better for a teacher who isn't quite sure to have the child checked out by a competent authority. Then there is the danger that a teacher will, either consciously or subconsciously, label a problem child the victim of abuse as a means of getting rid of him.

The American Humane Association has published a list of signs teachers should look for as possible child abuse and neglect tipoffs. Among them:

– If the child is aggressive, disruptive, or destructive, he could be acting out for attention. It could be the child's way of calling for help, of reflecting a destructive climate at home, or of imitating parental behavior.

– If the child is shy, passive, or overly compliant, he may have internalized his abuse problems and his cry for help is a whisper.

– A child who comes to school too early or loiters and hangs around after school is dismissed may be seeking an escape from home.

– A child who is always tired, sleeps in class, is lethargic or listless may be suffering from family problems that disrupt his normal routine.

The list also includes signs to look for in parents as possible indicators of abuse and neglect of their children. For example, parents may become aggressive or abusive when approached by teachers with problems concerning their children. They may be apathetic or unresponsive. They may be reported by their children as behaving strangely. They may simply fail to take an interest in their children's activities.

Many teachers are reluctant to become deeply involved in parental problems no matter what they are, but in child abuse cases, teachers can't separate the children's problems from those of the parents. In fact, current theories on child abuse treat the abusive parent as a victim also. In a large number of cases, the abusive parent was abused himself or herself as a child.

Often the parent is trapped by the pressures of a large family. He feels much like the teacher faced with a class of 30 acting-out students. Most abused children are not unwanted children, but frequently the parent acts in a fit of uncontrollable fury. In larger families an abusive parent will sometimes single out just one child for maltreatment.

It is not unusual to find a poor relationship between spouses in abusive families. As a result, mothers may look to their young children as a sole source of love; when the infant cries or the older child fails to respond in a satisfying way, she feels rejected. These chronic problems trigger the specific incidents of abuse whose signs the teacher sees in the classroom.

Dr. C. Henry Kempe, who has been working in the child abuse area for many years at the University of Colorado Medical Center, originated the term, "the battered child syndrome." He now estimates that 90% of the nation's abusive parents "are readily treatable by reconstituting their sense of trust and by giving them considerable minute-to-minute support over a crucial period of eight to nine months." In such cases it is not necessary to remove the abused child from the home permanently for placement in a foster or adoptive home.

The other 10%, says Dr. Kempe, "belong to the categories of abusive psychopaths or delusional schizophrenics" who use a child as a scapegoat. Dr. Kempe urges early removal of a child from the home in these cases.

Most teachers have neither the ability nor the training to recognize whether parents fall into the 90% or 10% group. Nor do teachers have time to give parents in the first group that "minute-to-minute" support. But they do have the responsibility, for the sake of the parent and the child, to guide such people, using channels set up by the school, to the social and welfare agencies that provide such help.

Today there are a number of parental treatment systems used throughout the country that appear to be working out well. At the National Center for the Prevention of Child Abuse and Neglect in Denver, a national training center run by the University of Colorado and directed by Dr. Kempe, four treatment methods have been developed that are being successfully used in various parts of the nation.

The first type uses lay therapists, both men and women, who work in the homes of abusive parents, providing support and spirit in times of need. The second is called the "crisis nursery," a place for parents to leave their small child when they feel the child needs a safer place. The nursery is open day and night, and a child may be left there for a few hours or a few days if need be.

Sources of Information On Child Abuse Problems

The following is a list of places for teachers to write for further information on the child abuse problem:

1. For a list of indicators of child abuse and neglect a teacher should know, write for "Guidelines for Schools" to the American Humane Association, Children's Division, P.O. Box 1266, Denver, Colo. 80201.
2. For information on the new federal child abuse legislation, write to the office of Senator Walter F. Mondale, 443 Old Senate Office Bldg., Washington, D.C. 20510.
3. For a copy of the New York City Schools' procedures for handling child abuse, write to the Board of Education's Office of Information and Public Affairs, 12th floor, 110 Livingston St., Brooklyn, N.Y. 11201. Request a copy of Special Circular No. 31, 1973-74.
4. For information on the role of educators and general information on child abuse, write to the National Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado Medical Center, 4200 East Ninth Ave., Denver, Colo. 80220.
5. For information about child abuse laws and reporting procedures where you live, contact your local social services agency, police department, and municipal and state governments.

Next, Dr. Kempe uses a day-care center for abused children, a place where abusive parents can see their young children with other children and discuss their feelings and experiences with other parents who share their problems.

The fourth method of treatment Dr. Kempe uses was actually begun in California in 1969 by a mother now known throughout the country as Mrs. Jolly K. Mrs. K. was a typical abusive parent who on one occasion threw a kitchen knife at her 6-year-old daughter, on another attempted to strangle the child, and at various times would harass and verbally abuse the girl.

Sensing the need to help herself, Mrs. K. went to 10 county and state facilities, but could not find help – probably because the child wasn't physically scarred. So she began a self-help group called Mothers Anonymous. Fashioned after the Alcoholics Anonymous system, it encouraged parents to meet once or twice each week and begin to appreciate the fact that they were not alone. They discussed their own problems as a group and began to derive a great deal of help and support from each other. Today the organization has been renamed Parents Anonymous. There are some six hundred chapters across the country.

Child abuse is a phenomenon any teacher may encounter, whether the school is in an urban ghetto, a middle-class area, or a wealthy suburb. It knows no class distinction, although middle- and high-income parents can often hide the problem better by avoiding public health facilities.

Sometimes people with more money can also "buy their way out" of potentially explosive child abuse situations by getting out of the house and becoming involved in other activities. The ability to pay for a steady babysitter can help save a child from abuse. Still, the teacher has to recognize that no particular class of parent is immune.

By doing nothing about suspected child abuse cases, the teacher is not only endangering the child and furthering the ruin of the parents, but is also contributing to the recycling of the problem. Abused children tend to become abusive parents.

The teacher's inaction also contributes to many other educational problems. Case studies have shown a strong link between abused or neglected students and pupils who later disrupt school activities. A study of 8,000 New York State children abused or neglected between 1951 and 1971 found that 35% of them later became known to the family court as juvenile delinquents or "persons in need of supervision."

But it is not only by a teacher's inaction that he or she contributes to the problem. Often a teacher directly contributes, too. Unfortunately, there are still large numbers of teachers who use corporal punishment as a behavior control technique. Such teachers often lose their own control in much the same way as an abusive parent. And every time a teacher uses corporal punishment, he is sanctioning the use of physical abuse. He is telling the class that it's okay to strike out physically against another person. He is helping students grow up with the notion implanted in their heads.

David Gil, professor of social policy at Brandeis University, is a well-known child abuse authority and an advocate for a national law to ban corporal punishment in schools. He says: "Such a message from the Congress could initiate a rethinking of the entire child-rearing context in the country. Without such rethinking and without an eventual redefinition of the status and the rights of children, child abuse can simply not be prevented."

The teacher cannot fight the battle all alone. Many teachers, in fact, don't report child abuse cases because they feel the social agencies don't follow them up, and thus it's a wasted effort on their part.

What the teacher can do, however, is work with school officials and get them to work with the social agencies to ensure that each reported case is followed through. If they have to, tenured teachers and their organizations can prompt such action by threatening legal steps or otherwise embarrassing lax officials.

Many professionals in the child abuse field are beginning to call for a complete teacher education program that would train the teacher, while in college, to recognize signs of abuse, work with abusive parents, and ensure the proper follow-up of reports by social and school agencies.

For their part, boards of education should be insisting that both administrators and teachers learn to recognize the problems. They can finance in-service training programs for both groups. Every school and school system in the country should have specific policies and procedures for child abuse reporting and follow-up.

A few school systems have recently recognized their responsibility and have begun child abuse programs. For example, the Montgomery County, Maryland, school system and Community School District 18 in Brooklyn, New York, both received grants from the U.S. Department of Health, Education, and Welfare last August for child abuse programs to begin this school year.

Both programs use special "remedial and reentry classes" for children in their districts who are identified as abused. The classes are designed to redevelop abused children's trust in adults as well as respect for themselves. At the same time, the children receive special academic help to compensate for the difficult periods they went through.

The Brooklyn program also includes development of a course of study for teachers, designed to train them to recognize child abuse and neglect at a "pre-crisis stage."

However, such programs are the exception, not the rule. Most school systems today provide very little real help to their teachers, and so perhaps it is up to the teachers to take the initiative. In the midst of an epidemic, you can't sit around and wait for miracles. The teacher can no longer sit around and wait for someone else to provide the solution.

"Unless changes are made in prevention and treatment, there will be 1.5 million reported cases of child abuse in the next 10 years [including] 50,000 deaths and 300,000 permanently injured children – most of whom will be brain-damaged," predicts Ray E. Helfer, a pioneer in the child abuse field from Michigan State University.

Teachers have got to start doing their share. It may be that the role of the teacher in the future will have to be part social worker, part counselor, and even part physician in recognizing abuse symptoms. So be it. With the exception of the parent, nobody sees the school-age child as much as the teacher, and teachers therefore must accept the responsibility to protect children against abusive parents. It is a teacher's job to ensure that children are educable as well as educated. ☐

Adah Maurer: There's a Near-Perfect Correlation Between Severity of Punishment and Aggression

> "... ethical judgments are changing rapidly from a willingness to live with primitive punitiveness to a recognition that permitting one child to be battered is to subject all of our children to the danger of victimization. When as an adult, the erstwhile battered child shoots 18 people from a Texas tower, kills 14 nurses in a Chicago residence, or slays a movie colony party in Hollywood, the blood is on the hands of those who would give aid and comfort to the punishing parents who shaped these lives without learning that corporal punishment is an ethical evil.

"Children will soon become a comparatively scarce commodity because of the new freedom vouchsafed women to control their own reproductive processes and to bear only such children as they wish. Scarcity increases value. The winds of change are blowing toward greater valuing of fewer children. Under these conditions it behooves experimentalists to confront ethical judgements now, and social, developmental, and educational psychologists to subject their ethical judgments to the rigor of careful assessment.

"Could we set aside our obsession with control? Could we, as the pediatricians have developed a symptomatology of the battered child, begin to develop a profile of the overpunished child?

"Work in progress indicates a near-perfect correlation between the amount and severity of physical punishment endured by a child from 2 to 12 and the amount and severity of antisocial aggressiveness that he displays during adolescence. . . . But during the years that the beatings are a daily diet and before the child is strong enough to retaliate or defend himself, he is in school and we should be able to recognize and rescue him. Could hyperactivity be environmental rather than genetic? Could short attention span be a survival tactic developed by the child in a continuously punitive home? Are there glandular changes, such as an increase in adrenalin output, that permanently change the body chemistry in the young human under continual severe stress? Are there 'soft signs' that point to overpunishment at least as clearly as signs point to neurological handicaps? What really is 'minimal brain damage,' and can these symptoms be induced by early brutality?

"All of these have been advanced as possible correlates of severe and prolonged physical punishment. A first study of the 'at risk' child sees him as one whose apparent brightness does not show up [in tests of intelligence]. He is danger-oriented, tense and guarded, visually hyperalert, lies blandly in defense of his parents, and seems precociously 'mature'. . . . Is this the whole picture? Here, again, control groups are needed, especially because many grown males will claim defensively that they were punished as children, suffered no ill effects, and certainly did not become criminal.

"These unknowns, rather than schedules of reinforcement or even rehabilitation techniques, must be unraveled before we can begin to see any hope that the next generation will be less traumatized and less violence-prone than our own."

(From Adah Maurer, "Corporal Punishment," *American Psychologist*, August, 1974, pp. 614-25) ☐

CRS-68

CHILD ABUSE

Hospital combats neglected health crisis

by Alan Meyers, M.D., Carol Cooper, and David Dollins

WITHIN THE past decade, there has been an increasing awareness of a major problem—neglect and physical abuse of children. The reports by Kempe et al., describing the "battered child syndrome,"[1] and by Fontana[2] have stimulated more than 500 reports appearing in the medical and social literature since 1962, as well as enactment of legislation in all 50 states.

Neglect and abuse of children ranges from deprivation of food, clothing, shelter, and parental love and supervision to incidents in which children are abused and mistreated physically by adults, often leading to disability, brain damage, or even death. In Kempe's report of 749 children, there were 78 deaths and 114 cases of permanent brain damage.

With increasing publicity and physician awareness, the number of abused children detected has increased. In New York City, from January 1971 to June 28, 1971, more than 2,200 cases of child abuse were reported. While this number represents only "the tip of the iceberg," it indicates a 549 per cent increase in reported cases in a four-year period. Indeed, at least 7,000 abused children, including 700 deaths, are reported annually to New York state officials. It has been estimated that 200,000 children in the United States require intervention, although some estimates are as high as four million children at risk of maltreatment, depending on the definition of abuse. These statistics become even more striking when one considers the observation that 15 per cent of all abused children reported to state agencies charged with child protection were dead after four years, and most of the remainder had residual damage.[3]

While physical abuse has attracted the most attention, a far greater number of children are at risk of nutritional, hygienic, and emotional neglect. It has been estimated that 30 to 50 per cent of all children diagnosed as having "failure to thrive" in infancy suffer maternal and/or paternal deprivation, often with severe psychological results. Furthermore, it is now possible to identify certain subgroups of children who are at risk of either physical abuse or neglect. These include children who have parents with drug addiction, who have had repeated episodes of "accidental" ingestion of a toxin, who are siblings or offspring of abused children, and who come from families with poor medical compliance.

While the perpetrators of the abuse often are not known to the medical personnel, usually they are the parents or the surrogate parents. Usually, one parent is active, while the other is a silent participant in the incident.

Child abuse occurs in all socioeconomic classes and ethnic groups. This widely based prevalence has been documented, although more cases are reported from the lower socioeconomic classes. There is significant under-reporting in the more affluent socioeconomic groups. Many reasons are offered for under-reporting. In a recent review, Sanders[4] lists the following:

- Lack of understanding by the clinician of the seriousness of the problem.
- Lack of awareness of responsibility for reporting the incident.
- Disbelief that the parents could be abusive.
- Reluctance to expose prosperous families to possible court hearings.
- Lack of knowledge about how to make a report.
- Reluctance to become involved in court hearings.
- Belief that the authorities will not take corrective action in spite of a report.
- Discomfort and resistance that the clinician feels when confronted with a battered child and his parents.

Initial hospital-based efforts

For these and many other reasons, administrative action is needed. In a large teaching hospital, members of the house staff often are reluctant to become involved with these issues, especially when there is a private physician on the case. The result is under-reporting and, most significant, inadequate action for the identification and the protection of the child as well as for the rehabilitation of the parents.

Yale-New Haven Hospital, New Haven, Conn., developed a hospital-based system for the detection, appraisal, reporting, and treatment of children believed to be abused, neglected, or at risk of maltreatment.[5] This program was organized after two clinical reviews by assistant residents in pediatrics at the

Yale-New Haven Hospital developed a hospital-based and communitywide program to identify, report, and provide follow-up care for abused children and rehabilitation for their parents

hospital in 1965 and 1967. The first report followed the admissions of five children with injuries ranging from skull fractures to severe dehydration, between July 1964 and April 1965. Although alternative living arrangements were obtained for all of the children by the social work department, the medical records contained no references to the neglect or abuse. A plea for further investigation was entered.

A child whose circumstances demonstrated the worst aspects of child abuse served as the precipitant for organization of a concerted program. This three-year-old child was dead on arrival, with numerous new and old fractures, burns, and hemothorax. The history was that "he rode his tricycle down the stairs." This and other such incidents led to feelings of distress and frustration among staff members, reflected in the name of the program DART—Detected, Admitted, Reported, Taken (from the home).

With this background and with a need for guidelines and mutual support, a program was developed. An ad hoc committee composed of two general pediatricians, a child developmentalist, a resident in pediatrics, two social workers, a child psychiatrist, and the hospital administrator was organized to formulate policies for the management of abused and neglected children. In order to maximize the likelihood of consistent and informed implementation of applicable laws and hospital procedures regarding suspected child abuse, a written policy was developed and was made available to all hospital personnel and house staff. After a brief statement of purpose and excerpts from state laws, written procedures were included with respect to the following basic questions:

- Who should be called for consultation if a suspected case of child abuse is identified?
- Who must concur in the diagnosis of suspected child abuse before the established reporting procedures are activated?
- Who is responsible for evaluating the family situation?
- What should be included in reports?
- What reporting procedures should be established both intrahospital and extrahospital?
- What steps should be taken if the child is believed to be in immediate danger?
- Who is responsible for providing clear and timely information to the parents regarding all actions taken?
- Under what circumstances should a law enforcement agency be called?
- How will pertinent information be filed?
- Under what circumstances are photographs to be taken?
- Who will assist the staff in preparing legal testimony?

The committee met as needed to evaluate immediate problems concerning injured children who were inpatients and those for whom immediate plans had to be made. In order to evaluate the less severe injuries and the cases of neglect, a subcommittee composed of the director of ambulatory pediatrics, a resident in pediatrics, and a social worker met weekly. This group concerned itself with those children believed to be at risk of receiving further injuries who were referred to the committee by the clinics and by the emergency department staff. If the committee determined that a child was at risk of abuse, administrative clearance was obtained to stamp the medical record cover with the word DART. The purpose of this procedure was to alert personnel that this child either was maltreated or was at risk of abuse. Thus, physical and social evaluation could occur prior to disposition, and further action aimed toward protection could be taken.

The current, expanded program

The referrals to the committee increased from five cases per year in 1965 to 51 cases per year in 1967. With the increasing work load, the need for staff assistance became apparent. A plan for expended services was developed, proposing that the hospital should initiate a communitywide program concerning child abuse, the DART registry should develop formal relationships with other local hospitals to implement common efforts toward recognition and treatment of abused children and their families, and an experienced social worker should be employed to provide various services. These services should be to:

- Coordinate the activities of the DART committee.
- Provide consultation to other hospital staff in assessing appro-

priate courses of action.

- Offer follow-up home visits for the purpose of assessing the situation of any child with a history of suspicious injuries diagnosed in the emergency department or in the clinics.
- Arrange for continuing medical and psychosocial assistance for children whose names are placed in the DART file.
- Perform periodic evaluations of children believed to be at risk.
- Provide ongoing casework for a limited number of families with children believed to be abused.
- Establish appropriate systems for the recording of material.

In accordance with Connecticut law, "Any child under 18 years of age who has had serious physical injury or injuries inflicted upon him other than by accidental means or has injuries which are at variance with the history given of them, or is in a condition which is the result of maltreatment such as, but not limited to, malnutrition, sexual molestation, deprivation of necessities or cruel punishment" must be reported to the state as a maltreated child. There is a $500 fine for failure to report.

All children suspected of having been abused are referred to the DART committee for disposition and for decisions regarding reporting. Plans for follow-up care are discussed. Referrals also are received concerning children for whom the staff is concerned about the parents' ability to nurture or to give care responsibly. Examples of such children include those who:

- Have had repeated "accidental" ingestion of toxin.
- Have families who have demonstrated poor medical compliance.
- Are born addicted to heroin, methadone, or alcohol.
- Are brought to the emergency department with vague complaints or severe parental anxiety or evoke suspicion of neglect.
- Have had siblings die under questionable circumstances.
- Have siblings known to be maltreated.

None of these examples are reportable under current law, but we believe these children to be at risk, and, therefore, they are included in the DART registry. During the past three and one-half years, a total of 758 referrals have been received, and 548 were believed to be at risk, while the remainder (210) were referred to the welfare department.

With the support of the hospital's auxiliary, a part-time social worker was hired, and volunteer assistance was obtained, enabling the program to move toward its goals and objectives. The current committee consists of a pediatrician who serves as chairman, a child psychiatrist, the chief pediatric social worker, the head nurse in the emergency department, a volunteer, and the social worker hired for the program. The addition of the emergency department nurse extended the program into the other area where children are seen, because children with trauma are seen only by surgeons. This nurse serves as a liaison for staff education and as a source for referrals.

The pediatric social service staff and the pediatric clinics continue to care for a large number of families, but the volume mitigates against provision of the services that are needed by these families. Although the child psychiatrists and developmentalists are available to assist in evaluation and planning, it is not possible for them to offer counseling to each family seen in the emergency department and in the clinics. In order to rectify this situation, we have applied for and have received financial support from the auxiliary for a full-time community case aide whose duties will be to contact and to offer immediate assistance to families seen under these conditions.

Other activities within the medical center, directed toward education and interdepartmental cooperation, include:

- Liaison with the emergency department by including its head nurse as a committee member. Liaison with the medical records department so that the emergency department staff is altered to the fact that a child is registered with the program, whenever a unit number is requested.
- Continuing education programs for all house staff as well as conferences on the battered child for other departments.
- Assistance from the department of volunteer services for the purposes of data gathering and evaluation of program effectiveness.
- Providing teaching seminars for the department of psychiatry, the hospital security department, other social service units, and students.

Role in communitywide efforts

Recognizing that the goal of referral and treatment of these families requires a communitywide

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approach, attempts are being made to evolve a model program within the county. Because families of maltreated children usually lack motivation and are isolated from their communities, an aggressive and ongoing treatment program is needed. The Greater New Haven Regional Committee on Child Abuse was organized to explore solutions to these problems. Its membership includes hospital staff, police, social agencies, state health and welfare departments, medical groups, volunteer groups, day care centers, and lawyers. Efforts are under way to design an innovative, cooperative service with the community.

Recognizing that solution to these problems also requires the formation of self-help groups, the auxiliary has served as staff for the formation of a local Parents Anonymous group, while the committee is available on a consultative basis. Furthermore, committee members have conducted educational programs at local colleges, for PTAs, and through the mass media in order to sensitize both lay and professional groups.

The DART program has been redefined to reflect the additional goals of protection and rehabilitation. The first two steps in the process, detection and appraisal, have been the easiest to accomplish. We have devised a sophisticated method of recognizing "at risk" factors in children and their families and are accumulating extensive files on these families. However, the ultimate goal, referral for rehabilitation and treatment, continues to be elusive and has met with limited success through intrahospital and extrahospital activities. ■

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REPORT
OF THE
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
TO THE
PRESIDENT AND CONGRESS OF THE UNITED STATES
ON THE
IMPLEMENTATION OF PUBLIC LAW 93-247,
THE CHILD ABUSE PREVENTION AND TREATMENT ACT

U.S. Department of Health, Education, and Welfare
Office of Human Development / Office of Child Development / Children's Bureau

Washington, D.C.

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TABLE OF CONTENTS

SUMMARY iii

INTRODUCTION 1

The Problem 1
The Act 1
Intradepartmental Committee on Child Abuse and Neglect 2
The National Center on Child Abuse and Neglect 3
The Advisory Board on Child Abuse and Neglect 5

I. DEMONSTRATION AND RESEARCH 6

Demonstration 6
Research 9

II. INFORMATION GATHERING AND DISSEMINATION 13

Activities of the National Center on Child Abuse and Neglect 13
Activities of the Intradepartmental Committee on Child Abuse and Neglect 14

III. TRAINING AND TECHNICAL ASSISTANCE 16

Activities of the National Center on Child Abuse and Neglect 16
Activities of the Intradepartmental Committee on Child Abuse and Neglect 19

IV. ASSISTANCE TO STATES 21

State Grants Under P.L. 93-247 21
Assistance to States Under Title IV Parts A and B of the Social Security Act 22
Central Registers 23
Other Assistance to States 23

CONCLUSION 25

LIST OF APPENDICES 26

SUMMARY

The Child Abuse Prevention and Treatment Act (P.L. 93-247) was signed into law on January 31, 1974, in response to the need for a coordinated Federal effort to assist in solving a complex, nationwide problem. Before the passage of the Act, several Federal agencies had initiated programs in this area, and the Department of Health, Education, and Welfare (HEW) had established the Intradepartmental Committee on Child Abuse and Neglect to coordinate the activities of all HEW agencies addressing the problem.

The Act created the National Center on Child Abuse and Neglect as a focal point for Federal efforts aimed at identifying, treating, and preventing child abuse and neglect. Placement of the National Center in the Children's Bureau of HEW's Office of Child Development emphasizes its concern with child welfare and development. The Act also created an Advisory Board, composed of representatives of all Federal agencies administering programs related to child abuse and neglect.

In carrying out the provisions of the Act, the National Center has initiated programs in four major areas: demonstration and research, information gathering and dissemination, training and technical assistance, and assistance to States. These programs are designed to increase understanding of the nature of the problem, to add to the knowledge about effective ways of dealing with the problem, to provide a central source from which to obtain information about child abuse and neglect, to improve the capabilities of agencies and individuals providing services to abused and neglected children and their families, and to help the States become eligible for the funds available only to them under the Act.

The major portion of the funds appropriated under the Act are directed toward demonstration and research. Demonstration programs structured in a variety of ways are now testing methods of delivering services to abused and neglected children and their families and of improving the capacity of existing regional, State and local agencies to identify, treat, and prevent abuse and neglect. An independent evaluation of each program will assess the effectiveness of the various methods and structures being tested. Evaluations will focus on organization of programs, staff training, cost-analysis and the combinations of services that are most effective with different population groups.

The National Center has funded 26 demonstration projects which will provide or arrange for direct services to abused children and their families. Seventeen demonstration centers in urban and rural areas will make available comprehensive child abuse and neglect services. Nine innovative programs will demonstrate new techniques for bringing these services to special groups, such as Native Americans, the military, and isolated rural and migrant families. The National Center will gain additional knowledge about effective organization of resources from 11 county and local child abuse prevention and treatment programs, which were jointly funded by two agencies on the Intradepartmental Committee, the Office of Child Development and the Social and Rehabilitation Service.

Grants were also awarded to set up 16 Resource Projects, with at least one in each HEW Region, to provide technical assistance and training to large numbers of professionals and agencies involved in combatting child abuse and neglect.

Sixteen research projects funded under the Act are examining hypotheses about child abuse and neglect -- especially those relating to the many environmental contexts of the family -- in an effort to increase the body of practical knowledge about the problem. These projects will investigate possible factors contributing to child abuse, including marital strife and economic and social stresses on the family, and will examine the relationship of drug abuse and alcoholism to child abuse and neglect. Researchers are also determining the feasibility of measuring the annual incidence of cases of child abuse and neglect, both the number of cases officially reported by States and the actual extent and severity of the problem.

As efforts to identify, treat, and prevent child abuse and neglect increase, the need for a central source of information about such efforts also increases. The National Center has undertaken the functions of information gathering and dissemination to fill this need. It is establishing a computerized system for collecting, storing, and retrieving research data and information about current programs in the field. It is compiling a summary of recent research and a directory of currently operating programs, as well as analyses of needs in these two areas, for publication next year. In addition, the information and findings coming from the various programs of the National Center and other Federal agencies are continually being disseminated to appropriate audiences.

Training and technical assistance are the most pressing immediate needs in the field of child abuse and neglect. Some substantial efforts in these areas were started by the Intradepartmental Committee. The National Center began its training and technical assistance activities by assessing the most critical needs and by preparing a set of monographs directed to practitioners in specific areas. It is now developing a series of curriculums to train medical, law enforcement, educational, and social services personnel in identifying, reporting, and referring cases of child abuse and neglect. The Center will also provide training in all aspects of handling child abuse cases to about 1,700 staff members in agencies and programs involved in serving children and families. Meanwhile, the most immediate needs for training and technical assistance are being addressed by some of the demonstration projects as well as by several intensive, short-term efforts. In addition, the regions are receiving help in developing 2-year strategies to meet regional needs for training and technical assistance.

Finally, the Act reflects the pivotal positions of States and their agencies in delivering services to abused and neglected children and their families by providing for grants to States meeting specified criteria. The scope and stringency of these criteria, aimed at effecting a uniform minimum level of procedures in case management and public education throughout the nation, require most States to make considerable legislative and administrative changes in regard to child abuse and neglect. Some States are having problems in complying with the requirement that they appoint a guardian *ad litem* to represent an abused or neglected child in all judicial proceedings. While some States see the need for court-appointed guardians, they maintain that the requirement is too costly and places a burden on their overloaded judicial systems. Other States are objecting to adopting the Act's definition of child abuse and neglect, because it includes "mental injury," which they consider to be difficult to define.

The National Center and the regional offices have worked intensively with the States to help as many as possible meet the requirements for these grants. To date, 16 States have become eligible and received grants, 12 of them conditional grants. Two more States will become eligible early in FY 1976. The National Center will continue to work toward the ultimate goal of bringing every State into compliance.

The programs initiated by the National Center since the passage of the Act are now beginning to show results. Some have already made significant contributions to the existing knowledge on child abuse and neglect. Most will continue into the future and await final assessments. Together, they constitute major progress on the road to creating an effective system for preventing, identifying, and treating child abuse and neglect throughout the nation.

INTRODUCTION

The Problem

Child abuse and neglect have existed probably for as long as there have been children and parents. But only within the last hundred years has society begun to shift from the notion that children are their parents' property and subject to any means of treatment and upbringing their parents may use. The enactment of child labor laws and the development of child protective services as part of the network of public social services were evidence of the nation's growing belief that children have certain rights as individuals, which society must protect.

In the early 1960's, the problem of the physically battered or severely maltreated child began to force its way into the public consciousness. Campaigns to enact child abuse laws in the States started to bring results, and today, all States and the District of Columbia have child abuse reporting laws.

Congress held lengthy hearings on child abuse and neglect in 1973. It found that, despite the progress made, insufficient resources had been directed toward preventing, identifying, and treating the problem. In too many States, the reporting laws were merely "window dressing," providing for the collection of information but not for adequate services for the child and the family. Even the collection of information was hampered by the wide disparity in definitions of child abuse and neglect from State to State. And when provision was made for treatment, it was often woefully inadequate because a complex, multidisciplinary problem is treated through a single discipline–understaffed and undertrained–to deal with the complexities of child abuse and neglect. Furthermore, while the measures for treatment were found to be inadequate, the measures for prevention appeared virtually nonexistent.

The Act

By nearly unanimous votes, Congress passed the Child Abuse Prevention and Treatment Act (P.L. 93-247), and the President signed it into law on January 31, 1974. Technical amendments were added in a bill signed January 4, 1975 (P.L. 93-644). The intent of the Act was to provide for–

- a broad and uniform definition of child abuse and neglect
- nationwide coordination of efforts to identify, treat, and prevent child abuse and neglect
- research leading to new knowledge and demonstration of effective ways to identify, treat, and prevent child abuse and neglect

. compilation of existing knowledge and dissemination of information about successful methods and programs

. training of professionals, paraprofessionals, and volunteers

. encouragement of States, as well as private agencies and organizations, to improve their services for identifying, treating, and preventing child abuse and neglect

. a complete and full study of the national incidence of child abuse and neglect

Intradepartmental Committee on Child Abuse and Neglect

The Department of Health, Education, and Welfare (HEW) also recognized the need for action in the area of child abuse and neglect. At the direction of the Secretary, the Intradepartmental Committee on Child Abuse and Neglect was established on June 22, 1973. Operating under the leadership of the Office of Child Development (OCD), the Committee was directed to coordinate all HEW programs concerned with child abuse and neglect, and the participating agencies were to set aside $4 million in fiscal 1974 for new projects to assist abused and neglected children and their families.

Since its inception, the Committee has met regularly, at first weekly or biweekly and subsequently on a monthly basis. OCD has maintained frequent communication among the participating agencies to evaluate progress and clarify issues. The projects administered by the Intradepartmental Committee are concerned with five main areas: better identification and reporting of abuse, developing and testing a variety of approaches to treatment, developing model programs aimed at long-range prevention, collecting and disseminating information to increase knowledge and public awareness of the problem, and conducting research related to child abuse and neglect.

Among the highlights of the Intradepartmental Committee's activities are the following:

. awarding of grants for 11 demonstration projects funded jointly by OCD and the Social and Rehabilitation Service (SRS)

. funding of an evaluation of the 11 demonstration projects by the Public Health Service

. funding of six research studies on problems of child abuse and neglect by the Office of Maternal and Child Health (PHS)

. developing and testing of a system for the reporting of the official incidence of child abuse and neglect by the States by OCD

. funding by OCD of self-groups such as Parents Anonymous

. funding by OCD of an Extended Family Center treatment demonstration

- exploring of the use of Medicaid program for the identification and reporting of suspected child abuse and neglect by SRS
- development of an evaluation system for measuring cost-effectiveness of child protective services by SRS
- funding of a research project by SRS to determine early warning signals of child abuse and neglect
- publishing a "state of the art" in research and an annotated bibliography of literature on child abuse by OCD and a "state of the art" in research and an annotated bibliography on child neglect by SRS
- holding conferences held in June 1973 and June 1974 on child abuse and neglect, sponsored by the National Institute of Mental Health and Children's Hospital of the District of Columbia, with publication of conference reports
- training Head Start personnel in the identification and reporting of child abuse and neglect by OCD
- initiating efforts by SRS toward developing program guides for the delivery of protective services
- funding by SRS of a national training program for training national leaders and 18 regional programs for training personnel providing protective services to abused and neglected children
- funding by the U.S. Office of Education of child abuse and neglect projects in three school systems
- revising regulations for Title IVA and B of the Social Security Act in accordance with provisions for State grantees in P.L. 93-247 by SRS
- revising of the Model Child Abuse Reporting Law and initiating the development of a model law for termination of parental rights by OCD

The National Center on Child Abuse and Neglect

Section 2(a) of the Child Abuse Prevention and Treatment Act created a National Center on Child Abuse and Neglect to administer the programs authorized by the law. Placement of the Center in the Children's Bureau of the Office of Child Development emphasizes its concern with child welfare and development. The National Center acts as the principal focus for Federal activity in developing policies, plans, and programs relating to the prevention, identification, and treatment of child abuse and neglect.

The Director of the National Center oversees two branches: the Program Policy and Planning Branch and the Clearinghouse Branch. The Program Policy and Planning Branch is responsible for programs on research, demonstration, training, technical assistance, and assistance to States under the Act. The Center also supervises the regional offices, in cooperation with the SRS regional staff, in their responsibilities in connection with compliance by States mandated by the Act for State programs under Title IVA and B of the Social Security Act. The Clearinghouse Branch is responsible for collecting and disseminating information and data on operating programs and current research.

In its first 18 months of operation, the National Center includes among its accomplishments the following highlights:

. developing and approving of research and demonstration application forms and instructions

  —awarding 33 demonstration center and resource project grants, as well as nine innovative demonstration projects

  —awarding evaluation contracts for the demonstration center projects and the resource demonstration projects

  —awarding 16 research grants

  —awarding a contract to perform a feasibility study investigating the national incidence of child abuse and neglect

. developing and implementing a clearinghouse of program and research information on child abuse and neglect

. awarding of a contract for developing training curriculums for personnel engaged in child abuse and neglect programs

. development of six monographs for persons engaged in child abuse and neglect programs

. awarding of five contracts for intensive efforts in the areas of training and of technical assistance in public awareness, State central registers, and needs assessment

. initiation of efforts in the development of standards

. development and approval of State grant applications and instructions, review of 40 applications, and award of 16 grants to States in fiscal 1975

. publication of regulations for programs supported under the Act

. development of proposed rules for the coordination of programs and activities supported by the Act and by other Federal funds

The Advisory Board on Child Abuse and Neglect

In response to Section 6(a) of the Act, the Secretary created the Advisory Board on Child Abuse and Neglect on March 29, 1974. The membership of the Advisory Board represents a variety of professions, departments, and agencies currently dealing with problems of child abuse and neglect. Included are representatives of all the agencies comprising the HEW Intradepartmental Committee on Child Abuse and Neglect.

In accordance with Section 6(a) and 7 of the Act, the Board has assisted the Secretary in developing proposed rules to coordinate all federally funded programs related to child abuse and neglect. Numerous Federal agencies are now involved in various aspects of research, demonstration, training, and technical assistance in the field. The regulations will cover all Federal activities in an effort to avoid duplication and promote cooperation and exchange of information. Other Federal laws, Titles IVA and B and XX of the Social Security Security Act, authorise Federal funds for services on problems including those related to child abuse and neglect problems.

One effort at coordination already completed is the publication in 1975 by the Office of Child Development of a booklet, *Child Abuse and Neglect Activities.* The booklet informs all agencies working in the area of child abuse and neglect of the nature and purpose of the programs, projects, and activities of HEW agencies. In addition, it is intended as information to anyone outside the Federal Government interested in descriptions of Federal activities related to child abuse and neglect, as well as those receiving funds under the auspices of the Intradepartmental Committee and the National Center for Child Abuse and Neglect.

The Advisory Board is also assisting the Secretary in the development of Federal standards for child abuse prevention and treatment programs and projects, in accordance with Section-6(a) of the Act. These standards will be suggested good practices for program operators and others covering the perspectives of social services, courts, law enforcement agencies, health and education agencies, voluntary organizations, and individuals. The aim will be to provide a total system within each jurisdiction for preventing, identifying and treating child abuse and neglect. Such standards will be made available to public and private organizations and State and local agencies for use on a voluntary basis.

The following sections of this report describe in detail the activities undertaken to implement the Child Abuse Prevention and Treatment Act, as well as other Federal efforts directed toward identifying, treating, and preventing child abuse and neglect.

I. DEMONSTRATION AND RESEARCH

Section 4(a) of the Act requires that not less than 50 percent of the funds appropriated under the Act be used for demonstration grants to public agencies or non-profit private organizations for training activities, establishment of regional centers offering a broad range of services, and other innovative projects. After testing and evaluating a variety of methods, the National Center on Child Abuse and Neglect will be able to disseminate information on the most promising practices for preventing, identifying, diagnosing and treating child abuse and neglect.

Section 2(b)(5) assigns to the Center another major function–to conduct research into the causes, prevention, and treatment of child abuse and neglect. Section 2(b)(6) specifies that a study be made of the national incidence and severity of the problem. The goal of most of the research now being conducted under federal auspices is to understand the causes and effects of drug abuse and alcoholism on child abuse and neglect.

Demonstration

Congress directed that the major portion of funds for child abuse and neglect programs be spent on testing various techniques for identifying, diagnosing, treating, and preventing the problem. The idea is to emphasize the practical–to find out what methods work and make the information available to persons involved in dealing with the problem throughout the country.

The demonstration programs were designed to cover a broad range of services and of methods of delivering them to abused and neglected children and their families. The intent is to improve the technology of intervention strategy by assessing the most effective means for delivering services. Each demonstration program, therefore, includes an independent evaluation, which will assess the structure of the service delivery program, the costs, and the resource requirements in terms of such elements as manpower, organization, facilities, and community coordination. The evaluation is a critical ingredient for converting the field experience into knowledge and information that can be passed on to others seeking answers to questions of program policy and service delivery.

Demonstration Centers. In December 1974, the National Center awarded 12 grants for Demonstration Centers, each project is expected to run for a minimum of 3½ years. Through these projects, the National Center is examining how comprehensive services for identifying, treating, and preventing child abuse and neglect can be organized and delivered most effectively. An additional five demonstration grants were awarded in June 1975.

The 17 Demonstration Centers are responsible for the total management of child abuse and neglect cases, including investigation, assessment, treatment, referral, public education, 24-hour hotlines, supportive services, and coordination with other agencies. They are using multidisciplinary teams of professionals—including physicians, psychologists, and social workers, paraprofessionals and volunteers—who are concerned with treating and maintaining the family as a unit.

The primary variables to be examined are (a) sponsorship—half the projects are run by health agencies and half by social service agencies, and (b) structure of delivery—half the projects provide direct services and half act as the coordinating mechanism for other agencies. Each of the four possible combinations of these variables is the overall structure for these projects.

Innovative Demonstrations. The National Center identified three high-risk groups that are not likely to be served adequately by existing agencies: Native Americans, military, and isolated rural children and their families. Section 4(a) of the Act suggests support "for such...innovative programs and projects...that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve."

Accordingly, a 3-year Innovative Demonstration program was launched in fiscal 1975, and nine grants were awarded in June—four for Native Americans, two for military families, and three for isolated rural communities. The National Center sees these projects as an extension of the 17 Demonstration Centers. But where the Demonstration Centers focus on variables of sponsorship and structure of delivery, the Innovative Demonstrations focus on the needs of unique target groups. And where the major urban centers, at least, have a whole array of services available, the availability of trained manpower and community resources is much more limited for the special target groups.

The Innovative Demonstrations will seek, within these special populations to create awareness of the problems of child abuse and neglect, provide a means of identifying the families, deliver necessary services, suggest approaches for improving family life so as to prevent abuse and neglect, coordinate available resources, and consider the unique legal constraints on Native Americans and military families. The objectives are to demonstrate new techniques for providing the services that best meet the needs of these groups.

Resource Demonstration Projects. The National Center established a third demonstration program to develop support services for State, county, and local public and private agencies engaged in programs on abuse and neglect. While the Demonstration Centers and the Innovative Demonstrations are designed to provide and/or arrange for direct and comprehensive services for abused and neglected children and their families, the Resource Demonstrations are directed at reaching individuals, agencies, and organizations who, in turn, provide services to those involved in abuse and neglect.

With fiscal 1974 funds, the National Center supported 10 projects to run for 3½ years. Of these, four are regional, four are statewide, and two focus on the needs of special groups—black families in metropolitan areas and the resources of State departments of education nationwide. Because the Act specifies geographic equity, the National Center solicited proposals and awarded grants from fiscal 1975 funds for six additional 3-year projects serving the regions not already covered. Thus the total 16 Resource Demonstrations include ten regional projects, five in selected States, and two directed at special target groups. The variables being tested, again, relate both to sponsorship and structure; in this case, the variables are especially focused on geographic extent of coverage and origination of the program, i.e., whether it emanates from an existing service program or from a teaching or planning agency.

The Resource Demonstrations are designed to promote more effective use of resources within communities to strengthen their capacity to cope with problems of child abuse and neglect. They are providing technical assistance to State and local program operators to help them initiate or improve services, and they are offering training to professionals and community agencies. The projects are expected to initiate a wide range of supportive activities as well as to identify the extent of need and the existing capability of the communities to serve the needs.

Evaluation reports of the Demonstration Centers and Resource Demonstrations are expected to be available annually beginning in February 1976.

Intradepartmental Committee Demonstrations. The Office of Child Development (OCD) and the Social and Rehabilitation Service (SRS) provided joint funding of $1.4 million for 11 county and local demonstration projects to assist the victims of abuse and neglect and their families, beginning in May 1974 and covering a 3-year period. A number of the projects seek to coordinate existing services to demonstrate effective ways of operating county-wide prevention and treatment programs. One project focuses on providing services on an Indian reservation, one is a live-in treatment program in a Los Angeles hospital for abused children and their families, and another is designed to establish a 24-hour center and hotline. Among those already showing evidence of success is a project making extensive use of volunteers in a four-county area of Arkansas and one in Virginia that has played a key role in new State plans and legislation for dealing with child abuse and neglect. The first annual reports from these projects are expected in September 1975. In addition, the Bureau of Health Services Research of the Public Health Service has awarded a contract to Berkeley Planning Associates to conduct an evaluation of these demonstration projects. The time and money spent on setting up a data base for this evaluation will not be duplicated by the evaluations of the demonstrations funded under the Act; rather, this evaluation is enabling the various programs to cooperate with one another, share knowledge and, ultimately, increase the total knowledge about effective ways to deliver services to identify, treat, and prevent child abuse and neglect.

OCD provided a grant to the American Humane Association (AHA) in Denver to demonstrate the feasibility of a system for collecting data from the States on the officially reported incidence of child abuse and neglect. Vincent DeFrancis, director of AHA's Children's Division, has developed a standard abuse and neglect case reporting form that has been adopted in 25 States and is under consideration in the others. The form—which has been revised and refined since the start of the demonstration—uses the broad definition of child abuse and neglect contained in the Act and seeks data on such specified characteristics of the child and family as age, number of siblings, and gross family income. No individuals are identified. The information will be used to compile periodic national, regional, and State reports on the offically reported incidence of child abuse and neglect, which can be used by professionals planning research and services and by States in the management of their programs of child protective services. At the end of the demonstration period, depending on the feasibility of the format, the National Center will decide whether to continue the effort as a function of the National Center.

A grant from OCD to Parents Anonymous of Los Angeles has as its purpose the expansion of the number of this type of self-help group from 80 to 200 chapters. Parents Anonymous was started by former abusing parents who seek to counteract the social isolation that appears to be one characteristic of abusing parents. With professional assistance from individuals (rather than agency representatives), the group offers parents support and an outlet for discussing problems of childrearing. The project seeks to demonstrate the need for such groups, their effectiveness in preventing abuse and neglect, and ways of identifying the type of individual best served by such groups. Informational materials on Parents Anonymous are being disseminated widely, technical assistance is being provided to communities wishing to establish local groups. An evaluation will be made of the 3-year effort.

The Extended Family Center, sponsored by the Mission Child Care Consortium in San Francisco, was established in February 1973 with support from OCD. It seeks to demonstrate the effectiveness of treating abused children and their parents through day care facilities for the children and counseling, group therapy, and other rehabilitative services for the parents. The number of services provided, makes this kind of program relatively expensive per family treated. However, if intensive treatment over a short period is successful, the program may be less expensive than more limited kinds of treatment that are less effective. Some evidence of the project's success is found in the State, local, and private support provided for continuation as OCD phases out its funding.

Research

While the demonstration programs are providing information about the effective delivery of services for immediate use, research is focusing on causes of child abuse, long-range prevention, and lasting remedial treatment. Past research, along with information from the presently funded demonstrations, have led to the formulation of hypotheses about these aspects of child abuse and neglect, some of which are now being investigated more thoroughly under the carefully controlled conditions of research projects.

Research Supported by the National Center on Child Abuse and Neglect. Pursuant to Section 2(b)(5) of the Act, which directs the National Center to "conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof," the Center staff reviewed the body of existing research in the field. They found that the focus of past Federal research efforts had been primarily assessing the effects of services provided in a crisis situation. They also found that few efforts had been made at studying the child in the context of the family and studying the family in the context of environmental and institutional factors.

The National Center, therefore, awarded 16 grants in fiscal 1975 for research projects directed toward four "contextual" areas. The largest group is examining the causes and/or precipitating factors within the family situation that contribute to child abuse and neglect. The researchers are studying interaction between the parents, the mother and her infant as well as such environmental factors as unemployment, housing, social conditions, alcoholism, and drug abuse, and how these affect the parenting abilities of the families involved. A few are examining predictive mechanisms that may be able to identify characteristics of persons at risk of abusing or being abused. A second group consists of two studies specifically relating to the impact of mood-changing chemicals—drugs and alcohol—on child abuse and neglect. A third group is looking at factors that influence parents to discontinue abuse and neglect as compared to those that produce recidivism. Finally, there are projects attempting to develop measures for determining the effectiveness of various intervention programs.

The expectation is that the knowledge gained from these research projects will be useful in improving programs and services and helpful to communities making program and policy decisions. Because most of the projects will be funded for 2 years, substantive findings will not be available until 1977.

Section 2(b)(6) of the Act directs the National Center to "make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number and severity." Although the demonstration by the American Humane Association has been testing a format for collecting data on *officially reported* incidence from the States, no system now exists to measure the *actual* incidence and severity of child abuse and neglect. Estimates range from 60,000 to 600,000 cases per year, but it is universally accepted that the actual incidence is far greater than the officially reported incidence. Some investigators have tried a variety of measurement techniques and have emerged with a variety of estimates, each a function of the technique used. A particularly difficult problem is assessing neglect which, while more prevalent than abuse, is also more diffuse in its definition. The National Center took the first step toward developing a valid measurement system by awarding an 9-month contract to Burt Associates of Bethesda, Maryland, to undertake a feasibility study and recommend possible methods of measurement and their relative cost-effectiveness. Results are expected by August 1975, and a plan for launching the incidence study is anticipated shortly thereafter.

Research Supported by the Intradepartmental Committee on Child Abuse and Neglect. The Social and Rehabilitation Service (SRS) has been exploring the feasibility of using the Early and Periodic Screening Diagnosis and Treatment program (EPSDT) as a mechanism for reporting cases of child abuse and neglect to the appropriate State agency. The effort is based on the assumption that the screening of 13 million children, aged 0 to 18, under the Medicaid program is a service delivery mechanism which can be used to detect early warning signs, and could be used for treatment or preventive efforts. The problems involved relate to the limitations of the EPSDT program as it now operates and to the risk of parents refusing to use the program if they fear reports of child abuse and neglect. Nevertheless, the activity has increased awareness among the EPSDT screeners of the need and legal requirements for reporting and treating suspected cases of child abuse and neglect.

SRS awarded a contract to develop an evaluation system for measuring cost-effectiveness of protective services to abused and neglected children. The contractor (a) reviewed systems for measuring such indicators of effectiveness as repeated occurrances and changes in severity of abuse and neglect in families that have received services from welfare departments and (b) developed techniques for estimating costs and measuring cost-effectiveness. These systems and measures were tested at selected State and local welfare departments, and a final report was submitted in July 1975.

Another SRS contract, awarded for 3 years to the School of Social Welfare, University of California at Los Angeles, is for determining early warning signals of serious neglect and abuse. The researchers are identifying elements necessary for, or injurious to, healthy growth and development of children, developing a rationale for studying specific situations or populations at risk, and developing and testing hypotheses about intervention methods for use in such situations or with such populations.

The Public Health Service (PHS), through the National Institute of Child Health and Human Development (NICHD), awarded four grants in fiscal 1974 for biomedical research projects related to child abuse and neglect. Subjects of the projects funded include factors such as birth order and sex of child that may affect the mother-child relationship, effect of family size and child spacing on family life, possible relation between population density and child abuse, and effects of parent education programs on mother-child relationships in low-income black families.

Health Services Administration, through the Maternal and Child Health, Title V research program, awarded grants to fund six research projects focusing on the problems of child abuse and neglect. One project was a follow-up study of traumatized children. Other projects are studying interdisciplinary approaches to prevention, identification of potential abusers, early identification of abused children and treatment modalities.

Research into the mental health aspects of child abuse and neglect is being funded by PHS through the National Institute of Mental Health. Included are a study of the formal and informal decision-making process in agencies handling child abuse cases, a study of eight child abuse and neglect programs under mental health auspices, a longitudinal study of physically abused children, and a survey of data on the incidence and social factors associated with child abuse and neglect cases in one community.

A study of social illnesses in children, being conducted by the Children's Hospital Medical Center in Boston with a grant from OCD, is attempting to distinguish characteristics of abusing families from those of families in which the children suffer other "social illnesses": failure to thrive, accidents, and ingesting toxic substances. Initial findings indicate that abusing families, on the whole, differ in background and outlook from the other families but that most similarities exist between abusing families and families whose children suffer from physical accidents.

A prospective study in child abuse by the Denver Department of Health and Hospitals, supported with OCD funds, is also studying the variables involved in nonorganic failure to thrive, abuse and severe neglect. Researchers are following all children coming into care of the Department under 4 years, providing intervention, especially medical and social services treatment, consulting and coordination, and comparing the children with similar children who receive regular protective services.

The National Institute on Drug Abuse is funding projects dealing with drug abuse in mothers and pregnant women. Two are residential and two are outpatient programs. All four are concerned, in part, with mother-child relationships and the childrearing problems of addicted mothers.

The National Institute on Alcohol Abuse and Alcoholism is funding five projects, starting in fiscal 1975, on alcoholism and child abuse and neglect. Included are services to the children of problem drinkers, development of family therapy techniques to prevent child abuse and neglect, a study of the effects of alcoholic parents on the development of children, and a self-help program for families in which alcoholism occurs.

II. INFORMATION GATHERING AND DISSEMINATION

The Congressional hearings identified a strong need for a central point for obtaining information about child abuse and neglect. Section 2(b)(1) of the Act directs the National Center to "compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect." Section 2(b)(2) further directs it to "develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect."

The Clearinghouse Branch of the National Center is now working to implement both of these directives. It is compiling official incidence data on child abuse and neglect and collecting substantive information about research projects and service programs on child abuse and neglect throughout the country.

Activities of the National Center on Child Abuse and Neglect

Virtually every activity of the National Center works, to some degree, toward gathering and disseminating information and/or data. The reports of the research and demonstration projects are expected to provide useful information for persons working in the field of child abuse and neglect. Materials developed for training and technical assistance—among them six booklets providing assistance to various types of professionals, training curriculums focused on four key professions, materials for public awareness campaigns, and standards for program operators—are all scheduled for nationwide dissemination. Model child abuse and neglect laws and recommendations for central registers will be disseminated to the States.

Besides these activities, several efforts of the National Center are specifically focused on gathering and disseminating information and data on child abuse and neglect. Included is a contract awarded to Herner and Company, Washington, D.C., to establish a computerized system for storing and retrieving program and research information. The other activities described below are also under contract, while the National Center is developing its staff capability to continue the functions on an annual basis through its own facilities.

Program Information. By July 1976, the National Center will have compiled its first annual directory of currently operating programs in child abuse and neglect. The information, gathered through a continuing survey, includes the identity and location of each program, the nature of services, the geographic area served, staff, and similar facts. At the same time, the National Center expects to issue an analysis of current programs in terms of types of services available and the existing needs for services in identifying, treating, and preventing child abuse and neglect. This document should be especially useful to program planners and policy makers at national, regional, State, and local levels.

In addition, the National Center will continually respond to specific requests for information about programs by retrieving the desired information from the computerized system.

Research Summary. Also in 1976, the National Center plans to publish its first summary of research in child abuse and neglect, covering studies conducted during the calendar years 1965-74. The publication will include information, now being computerized, consisting of abstracts, indexes, and bibliographies of current research. In addition, an analysis of the findings will indicate the needs for future research. This analysis should be particularly useful to agencies making plans for research programs and to individuals seeking support for research in child abuse and neglect.

Activities of the Intradepartmental Committee on Child Abuse and Neglect

Many of the efforts of the Intradepartmental Committee in gathering and disseminating information on child abuse and neglect have provided a foundation—and, in some cases, even a skeletal structure—on which the National Center is now building to produce a complete informational resource.

With a grant from the Office of Child Development (OCD), the Social Research Group of the George Washington University did a brief survey and analysis of recent research in child abuse and neglect, resulting in the 1974 publication *Child Abuse and Neglect: A Report on the Status of the Research.* The Social and Rehabilitation Service (SRS) provided a grant to the Social Welfare Policy Institute at the University of Georgia to survey research in child neglect. The two-volume report, *State of the Art of Child Neglect,* includes descriptions and analyses of studies as well as an annotated bibliography. These two publications serve as useful background for the National Center's current efforts at compiling comprehensive data on all recent research in child abuse and neglect.

Another OCD project, begun in FY 1974, described more fully under "Training and Technical Assistance," was designed specifically to disseminate information about a 24-hour comprehensive emergency program which deals in part with problems of child abuse and neglect. The project is offering technical assistance to potential State and local operators of similar programs, as well as testing the effectiveness of the dissemination strategy for its potential use with other successful research or demonstration projects.

Some efforts of the Intradepartmental Committee have begun as information gathering and/or dissemination but in the long run have developed or will develop into technical assistance, research, or demonstration projects. One such effort is an OCD-funded survey by Dr. Saad Nagi at the Mershon Center, Ohio State University, of the structure and performance of programs of child abuse and neglect. Through questionnaires and interviews, the survey has covered programs in 160 counties across the country and gathered data from persons officially involved with cases of child abuse and neglect in five areas—social services, hospitals, courts, police departments, and schools. Initial findings include the best estimates of incidence now available, an assessment of the extent of existing services, statistics on the use and coordination of resources for treatment and referral, and identification of strengths and weaknesses in local programs.

Another effort started as information gathering and led directly to further research. SRS's Community Services Administration surveyed 10 State and 30 local welfare departments, identifying problems in providing services to abused children. The findings are available to State welfare departments and other interested agencies. At the same time, SRS used the findings to develop the Request for Proposals for analyzing evaluation systems for measuring cost-effectiveness of protective services, described under "Demonstration and Research."

A national conference on child abuse and neglect was held in Washington, D.C. June 8 and 9, 1973, under the joint sponsorship of the National Institute of Mental Health (NIMH) and the Children's Hospital of the District of Columbia. Participants included approximately 100 experts in the field from Federal, State, and local public and private agencies and organizations. Workshops centered on (a) improved definitions and identification of the problem; (b) current and proposed legislation; (c) efforts directed at prevention and rehabilitation in terms of needed community services; (d) improved educational programs for those involved in identifying and treating child abuse and neglect, for parents, and for the community as a whole; and (e) needs for research and information. Some of the pivotal issues discussed were the need for a broad definition of child abuse and neglect, the need for the then proposed National Center on Child Abuse and Neglect to be authorized to conduct research and demonstration as well as to gather and disseminate information, the need for a broad and flexible attack on the problem, and a suggestion for preserving the anonymity of abusing or neglecting parents seeking help. NIMH published a report of the conference, which has been disseminated widely. Because the conference was held after the Congressional hearings but before the passage of any bills on child abuse and neglect, it served as a useful platform for discussing ideas and issues that may have aided Congress in developing the Child Abuse Prevention and Treatment Act. A second national conference sponsored by NICHD June 17 and 18, 1974, was devoted to issues in developmental research in child abuse and neglect.

III. TRAINING AND TECHNICAL ASSISTANCE

The greatest immediate need in the field of child abuse and neglect is for training and technical assistance. Technical assistance, provides policy makers and program managers with knowledge about a variety of alternatives and with some assessment of the best practices in the various areas of the field. Training enhances the skills of the practitioners and supervisors who are directly involved in treating abused and neglected children and their families and those many categories of professional, paraprofessional, and voluntary practitioners whose work involves them to some degree in identifying, treating, and/or preventing child abuse and neglect.

Activities directed toward research, demonstrations, and information gathering and dissemination will, of course, provide assistance in the form of new knowledge and information for policy makers, program operators, practitioners, and the general public. But the need is immediate. Programs of training and technical assistance were initiated by the Intradepartmental Committee and are continuing; the National Center has started new programs, even while it awaits the results of other activities that will further enhance and refine both the procedures and the substance of future training and technical assistance.

Activities of the National Center on Child Abuse and Neglect

One of the problems of designing programs for training and technical assistance is that the situation is such a dynamic one. Needs change. Especially since the passage of the Act, information and resources in the field of child abuse and neglect are becoming available in large amounts and in a concentrated period of time. Yesterday's needs are filled, today's are different, and tomorrow's must be estimated.

Section 2(b)(3) of the Act directs the National Center to "compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect." Section 2(b)(4) directs it to "provide technical assistance...to public and nonprofit agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect."

As a first step toward carrying out these directives, the National Center conducted a brief survey and assessment of the needs of agencies and organizations delivering services to abused or neglected children and their families in the summer of 1974. Visits were made to about 18 agencies in 12 States, and about 70 persons were interviewed. Many of the specific needs identified at that time are no longer so pressing, while others have risen in priority. But the assessment did serve to identify several broad areas and objectives to be pursued.

At the same time, the National Center was working on developing materials for dissemination to persons delivering services for the prevention, identification, and treatment of child abuse and neglect. The result is a set of six monographs, to be published in the fall of 1975. Three of the monographs combine to make a set, entitled *Child Abuse and Neglect: The Problem and Its Management.* Volume I is an overview, examining child maltreatment from such perspectives as characteristics of parents and children, effects of child abuse and neglect, a psychiatrist's point of view, and State reporting laws. Volume II discusses the roles of some of the many professionals and agencies involved in case management; those working with abusive parents, child protective service agencies, physicians and hospitals, the police, and teachers. Volume III suggests coordinating community resources for managing and preventing child abuse and neglect. The examples and suggestions are intended not as models but as ideas to stimulate thinking. The three remaining booklets are separate publications: *Putting Central Registers to Work,* by Douglas J. Besharov; *Working with Abusive Parents from a Psychiatric Point of View,* by Brandt Steele, M.D.; and *The Diagnostic Process and Treatment Programs,* by Ray E. Helfer, M.D.

In December 1974, the National Center awarded a contract to Urban and Rural Systems Associates (URSA) of San Francisco to develop a set of curriculums to train medical, law enforcement, educational, and social services personnel in identifying, reporting, and referring cases of child abuse and neglect. URSA has completed an analysis of existing training materials, and the findings indicate that very little is now available. The project is designed to develop a core curriculum that deals with elements of common interest to all the professions–historical development; key issues; involvement at Federal, State, and local levels; causes and precipitating factors of abuse and neglect; intervention strategies; up-to-date information and data. Further, it will develop four separate curriculums, one for each professional area, going into greater depth on identification, reporting, and referral from the perspective of the specific needs of each group. The training package will deal with knowledge and attitudes, but the primary focus is development of skills. It is to be completed in July 1976 and provide 36 hours of training, both inservice and preservice, with heavy emphasis on audiovisual materials. It is hoped that the core curriculum will be used in combined sessions for members of all the groups, in order to encourage communication and coordination among the various disciplines involved in handling child abuse and neglect cases.

The National Center plans to take an active part in implementing the training package. When it is complete, contracts will be awarded to conduct training demonstrations using the materials. These activities are scheduled for fiscal 1977.

Meanwhile, under the direction of the National Center, the regional offices are developing 2-year training and technical assistance strategies to meet regional needs, to be carried on during fiscal 1976 and 1977. The urgency of the need for training dictates that these activities be started before URSA's curriculum package is completed, but when it is available, it will become an important resource for these efforts.

Training and technical assistance for personnel in currently operating child abuse and neglect programs are being provided over a long term by the 3-year Resource Demonstration Projects, described under "Demonstration and Research." A principal function of these projects is to provide assistance to agencies and organizations delivering services to abused and neglected children and their families, to enable the agencies to improve and coordinate existing services and initiate new ones where needed.

This same kind of "operational" training and technical assistance is needed over the short term, as well. Thus the National Center has awarded five contracts, for periods ranging from 7 to 18 months, to provide training and technical assistance in the areas of the most critical need. Internally, the National Center is coordinating the short- and long-term efforts so that the knowledge gained from each is shared among the others. The five short-term contracts include intensive efforts to provide immediate substantive training in high-priority areas as well as to develop new and long-range resources that will be useful in the Resource Demonstration Projects, in the activities of the regional offices, and in other operationally oriented training and technical assistance efforts.

The first of these contracts is a 7-month survey and assessment of technical assistance needs leading to the development of a 2-year training and technical assistance strategy and work plans for each region for implementation. The objectives are to survey existing resources and programs and propose alternatives, policy issues, and goals for the 2-year strategy.

Second are two contracts to provide training for personnel in organizations and agencies responsible for providing services in child abuse and neglect cases in each of the ten DHEW regions and among Native American populations. About 1,700 persons will receive training designed to improve skills and develop multidisciplinary teamwork between July 1, 1975 and March 1, 1976.

Third is a 12-month contract to provide technical assistance in developing public awareness programs and materials. This effort will assess existing resources for public awareness programs, provide technical assistance to selected communities for developing public awareness campaigns, and create prototype materials (radio and television spot announcements, mass transit displays, posters) and a guidance manual as resources for other communities interested in launching such programs. The objectives are to inform the public in general about child abuse and neglect; to increase detection and reporting of suspected cases, and to reach geographic, ethnic, or cultural groups not presently receiving such information.

The last contract is concerned with State central registers and is described more fully under "Assistance to States."

Finally, mention should be made here of the standards for program operators and communities described among the activities of the Advisory Board in the Introduction. These standards are expected to be completed by the middle of fiscal 1976, at which time they will be disseminated to an extensive list of public and private agencies, organizations, and individuals and to other persons or groups.

Activities of the Intradepartmental Committee on Child Abuse and Neglect

Efforts at training program operators and practitioners delivering services to abused and neglected children were initiated by the Intradepartmental Committee in fiscal 1974. The Social and Rehabilitation Service (SRS) awarded a grant for a national training program to train trainers and 18 regional grants to provide 2- and 3-day training sessions for (a) staff of State and local public welfare departments, (b) staff of voluntary social agencies, (c) law enforcement officials and court personnel, (d) health and medical personnel, (e) school personnel, and (f) personnel in facilities providing care and services. In addition, the grantees are to develop training materials for use with these and similar groups. Three follow-up workshops were held in 1975--in New Orleans in March and in New York and Chicago in June--to enable the trainees to report on their activities and to refine the materials they had developed. The training materials and a final report on the completed activity are expected in August 1975.

Results of the extensive coordination by the National Center are evident in that the Intradepartmental Committee efforts here are scheduled for completion at the time the National Center efforts begin. The training materials developed by the SRS grantees will become resources for the two intensive training projects of the National Center as well as for other training and technical assistance efforts.

SRS has made a training grant to the Law School of the University of Oregon to develop a manual on the legal aspects of services to abused and neglected children and to provide training to agency staff and to lawyers in this important aspect of prospective services. The manual will cover the role and jurisdiction of the court, rules of evidence, filing a petition, testimony, disposition of cases, guardianship and custody, and termination of parental rights. The guides will assist protective service workers in understanding children's and parental rights and due process of law since any protective service case may go to court.

The Office of Child Development (OCD), through a grant to the Urban Observatory in Nashville, has disseminated information on a highly successful 24-hour emergency services program in that city. Materials include a brochure for the general public, a manual for agency officials, a pamphlet directed to legislators and other decision makers, and a training packet for emergency caretakers. In addition, technical assistance is being provided to 30 States or localities in establishing their own similar crisis center.

OCD has provided training for the local staff of 200 Head Start projects. The training, which started in fiscal 1974 and continued through fiscal 1975, dealt with preventing, identifying, and reporting child abuse and neglect. OCD is now developing program guidance to define the role of Head Start projects in responding to problems of child abuse and neglect, field-testing a policy in selected regions, and preparing for its revision and implementation. In addition, the training of additional local Head Start staff will continue.

The U.S. Office of Education (USOE) awarded 3-year grants to three local school districts under Title III of the Elementary and Secondary Education Act. The districts are developing models to train teachers to (a) identify abused and neglected children, (b) report suspected cases and work with other community resources to alleviate the problem, and (c) develop skills to help abused and neglected children overcome emotional trauma so that they may learn effectively.

The National Institute of Mental Health (NIMH) has funded an 18-month project at Children's Hospital Medical Center in Oakland, California, to develop, test, and evaluate training models for the identification, treatment, and case management of child abuse and neglect. The models are intended to be used with policy and planning officials, as well as staff in mental health, medical, welfare, probation, school, and law enforcement programs.

The Education for Parenthood project is a cooperative effort among OCD, USOE, and NIMH. Its purpose is to improve the competence of adolescent boys and girls as prospective parents as well as to prepare them for possible careers in working with children. A new curriculum for secondary school students, *Exploring Childhood*, has been developed and is now being disseminated. An intensive public education campaign seeks to introduce the course into schools, while grants to seven voluntary youth organizations are intended for the design of parenthood education projects to reach young persons outside the schools. Approximately 1,090 schools, universities and other organizations are now using "Exploring Childhood"...of these about 900 are public or private schools. Technical assistance is available to schools desiring to implement the program.

Finally, the Public Health Service (PHS) through a grant to the American Academy of Pediatrics, has conducted a survey of services provided by a sample of health-based, multidisciplinary child abuse programs. The survey report describes the procedures and practices of these programs in the context of their communities, indicating both commonalities and differences. Based in part on this survey, PHS has drafted guidelines for 1,500 PHS projects and their affiliated hospitals on identification and management of child abuse and neglect cases. The projects include Children and Youth Programs, Maternal and Infant Care Projects, and Migrant and Neighborhood Health Centers. Dissemination of the final guidelines is expected in fiscal 1976.

IV. ASSISTANCE TO STATES

States are in a pivotal position for bringing about the prevention, identification, and treatment of child abuse and neglect. Social services, education, health, law enforcement, and the courts are the province of State and local governments. The State agencies and their local components, therefore, are the primary deliverers of services to abused and neglected children and their families.

Section 4(b)(1) of the Child Abuse Prevention and Treatment Act specifies that between 5 and 20 percent of the money appropriated under the Act may be used for grants to States to assist them "in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs." In addition, States and State agencies are eligible to apply for research and demonstration grants and to receive technical assistance and staff training. Four State agencies are conducting demonstrations in child abuse and neglect services through the Resource Demonstration Projects described under "Demonstration and Research." Numerous projects are providing training and technical assistance to personnel in State agencies.

The principal source of assistance to States, however, has been Section 4(b) of the Act. Assistance, of course, may be monetary or technical. Through fiscal 1975, most of the assistance has been technical. As the technical assistance begins to show results, however, in the form of bringing the respective States up to eligibility for funds, the assistance will begin to be more heavily of a monetary nature.

State Grants Under P.L. 93-247

Section 4(b)(2) of the Act lists ten requirements which a State must meet in order to qualify for a grant under Section 4(b)(1). Regulations published December 19, 1974, further interpret these requirements. HEW Form 627, "Eligibility Statement for State Child Abuse and Neglect Grant Programs," provides even further interpretation by rephrasing each regulation into questions and explaining how the State can meet the regulation. Some of the requirements can be met only by being enacted into the State's legislation. Some can be met through administrative procedures, and some can be met by a statement from the Governor.

The requirements are rather stringent. They deal with effective reporting procedures, immunity for reporters, investigation of reports, administrative procedures, personnel and training. They demand such safeguards as confidentiality of records and guardians *ad litem*. They set minimum standards for cooperation among agencies, for dissemination of information to the public, and for ensuring preferential treatment of parental organizations combatting child abuse and neglect. They require, also, that Federal funds supplement and not supplant State funds already being expended on child abuse and neglect programs. Prior to the passage of the Act, most States had not been working with as comprehensive a definition of "child abuse and neglect" as the Act and the regulations direct. Many States have problems with providing a guardian *ad litem* in every judicial proceeding involving the victim of child abuse or neglect. The National Center staff estimated that perhaps only one State would be eligible for a grant immediately and that many of the rest would need substantial changes in their laws and/or administrative procedures.

Nevertheless, the States were encouraged to make application in fiscal year 1974, even if they knew they would not be eligible. The Assistant Secretary for Human Development sent a letter to each Governor, announcing the availability of the grants. Regional offices were asked to encourage the States to apply. Of the funds appropriated for fiscal 1974, 5 percent was set aside for State grants.

In all, 23 States (of the 56 units defined as "States" for purposes of the Act) applied for funds in fiscal 1974. Five were awarded grants, conditional upon further clarification that they had met the eligibility requirements. Hawaii and Tennessee were given their awards; Georgia, New York, and California failed to comply with the requirements of the Act for State grants.

In the meantime, with the eligibility statements in hand, staff members of the National Center and the regional offices were able to work with all the States not awarded grants to help them meet the eligibility requirements. In many cases, the review from the legal standpoint required lengthy analysis and interpretation of various laws, legal opinions, and administrative provisions in a given State.

In January 1975, notice went to the States announcing that 20 percent of fiscal 1975 funds had been set aside for State grants and the deadline for applications would be April 18. This time a total of 40 States applied. The National Center allowed additional time for the legislative activity necessary in some States, extending deadlines for eligibility statements into June. By the end of that period, 16 States were awarded grants, 12 conditional, according to the prescribed formula, and the remaining money was reallocated for other National Center activities. In each case, the State social service department was designated by the Governor as the recipient of the grant. Further efforts will continue to be made in subsequent fiscal years with the goal of bringing every State into compliance with the eligibility requirements.

Besides the lengthy review of applications from the legal standpoint, the National Center has expended considerable efforts in reviewing the program proposals. States were encouraged to avoid merely increasing existing staff and to concentrate on moving into new areas and developing new programs that could bring greater results. By and large, the States have proposed to use the grant funds for such new activities as public awareness programs, statewide telephone systems, establishment of crisis centers, and the like—a trend the National Center views as positive.

Assistance to States Under Title IV Parts A and B of the Social Security Act

Parts A and B of Title IV of the Social Security Act provide Federal grants-in-aid to State agencies. Part A provides financial assistance and services to families with dependent children. Part B provides grants for child welfare services. Under the AFDC program, protective services must be provided to abused and neglected children. Section 4(b)(3) of the Child Abuse Prevention and Treatment Act specifies that programs and projects related to child abuse and neglect assisted by Parts A and B must comply with a specified four of the ten requirements in Section 4(b)(2) in order to *continue* to receive these grants. The Social and Rehabilitation Service (SRS), which administers the Social Security Act, drafted proposed rules for these criteria in cooperation with the National Center.

SRS and the Office of Human Development have also worked out an agreement for joint review and approval of amendments to Title IV State plans in response to Section 4(b)(3) of the Act and to the regulations. The same two agencies have agreed, as well, to coordinate the technical assistance they provide States.

There is considerable pressure for the States to comply with the four requirements, which relate to reporting known or suspected abuse and neglect, investigation of reports, confidentiality of records, and cooperation among agencies, using the definition of child abuse and neglect of the Act and regulations. While States have not generally separated their expenditures for child protective services from other services under Title IV, Parts A and B, of the Social Security Act, estimates suggest that support for child abuse and neglect programs run to several tens of millions of dollars annually. Of the $46 million appropriated annually for child welfare services under Part B, $31 million is spent on foster care and a substantial portion of that figure is estimated as being spent in relation to child abuse and neglect.

Central Registers

One of the five training and technical assistance contracts described under "Training and Technical Assistance" is specifically designed to provide assistance to States. It is an 18-month contract to help develop and improve State central registers.

As one mechanism in the effective management of child abuse and neglect cases, central registers have already begun to prove their worth. They may serve as a means of receiving and analyzing reports, of referring the reports to appropriate agencies, of storing data on a particular case, of linking reports of repeated incidents with a particular family, and of providing a mechanism for the effective management of child abuse and neglect cases. The contractor will assess the operations of a sample of central registers; develop models for States to use in improving their systems, including provisions for confidentiality of information; and provide training and technical assistance to States, Resource Centers, and the staff of the National Center.

Other Assistance to States

In 1962, the Children's Bureau developed a Model Child Abuse Reporting Law as a guide for State and local governments in using reporting to deal with problems of child abuse and neglect. During calendar 1974, the Institute of Judicial Administration at New York University, with a grant from the Office of Child Development (OCD), worked on revising and updating the law. With the passage of the Child Abuse Prevention and Treatment Act, that law became too limited, especially in its definition of child abuse and neglect and in the specification of those who must or may report suspected cases. OCD staff decided to revise the law further, to include all the eligibility requirements of States in Section 4(b)(2) of P.L. 93-247 that can be met by State legislation. A State adopting this model law will thereby meet the legislative requirements for receiving State grants. The final product is expected to be available for dissemination by late 1975.

A second model law is also being drafted by OCD. This is not an Intradepartmental Committee effort but one of OCD as a representative agency on the Advisory Board. In managing cases of child abuse and neglect, the strategy of choice is to rehabilitate the abusing or neglecting parents, to solve the problems underlying the abuse or neglect, and to maintain the family as a unit. Unfortunately, the best interests of the child occasionally demand that the child be removed from the family permanently. When the decision is made to use this last resort, the child is best served if a permanent home is found as quickly as possible. Boston College Law School has been examining the legal bases for termination of parental rights as well as aspects of minority cultural, socioeconomic, and ethnic mores that need to be considered. Upon completion, the model law will be disseminated to State and local governments.

The Department of Justice, also represented on the Advisory Board, is engaged in some activities related to problems of child abuse and neglect. Among them is a grant from the National Institute on Law Enforcement and Criminal Justice to the Institute of Judicial Administration to prepare 26 volumes of legal and administrative standards to improve the effectiveness and efficiency of the juvenile justice system. One of the volumes will focus specifically on child abuse and neglect. Another activity is the participation of the Office of Special Litigation, Civil Rights Division, as plaintiff, plaintiff-intervenor, and *amicus curiae* in cases involving the constitutional rights of juvenile offenders. Many of the cases involve allegations of abuse and neglect on the part of State agencies or employees charged with the custody of civilly committed juveniles.

CONCLUSION

Since the passage of the Child Abuse Prevention and Treatment Act, the National Center on Child Abuse and Neglect has expanded, broadened, and built upon the Federal activities that were begun earlier. To implement the provisions of the Act, the National Center has launched a variety of new programs, most of which are now in their first phase of gathering data, developing models, and initiating action. In some instances, the activities have moved to the second step of analyzing data.

Starting in fiscal 1976, the efforts of the National Center should begin to show substantial results in influencing policy decisions and operational procedures for child abuse and neglect programs throughout the nation. Taken together, they represent something more than a beginning of concern with the problem of child abuse and neglect. Through the information gained from the studies, the techniques revealed by the demonstrations, the methods established by training and technical assistance, and the improved systems developed by States and their local agencies, they provide a baseline for measuring the accomplishments of the future.

LIST OF APPENDICES

1. Public Law 93-247, with amendments, the Child Abuse Prevention and Treatment Act
2. Child Abuse and Neglect Activities Funded to Date*
3. Charter of the Advisory Board and list of members
4. Statement of Organization and Functions, National Center on Child Abuse and Neglect
5. Regulations – "Child Abuse and Neglect Prevention and Treatment Program," December 19, 1974 (45 CFR Part 1340)

*The numerals in parenthesis, appearing after the project date, indicate the stage of funding, i.e.,
(1) indicates that this is the first year in which the project has been funded
(2) indicates that this is the second year in which the project has been funded
(3) indicates that this is the third year in which the project has been funded

RESEARCH AND EVALUATION

Projects Funded by the National Center on Child Abuse and Neglect

Evaluation of Selected Child Abuse and Neglect Service Components

Ms. Janne B. Dinges
State Department of Public Welfare
John H. Reagan Building
Austin, Texas 78701
6/30/75 — 6/29/76 (2)
$200,000

Abuse and Neglect Among Low-Income Families: A Comparative Study of Adequate and Inadequate Child Care

Dr. Bernard Horowitz
New Jersey Division of Youth and Family Services
One South Montgomery Street
Trenton, New Jersey 08625
4/1/75 — 3/31/76 (1)
$163,047

Causal Factors in Neglect and Battering: A Prospective Service

William A. Attemeier, III, M. D.
Vanderbilt University Hospital
Department of Pediatrics
Nashville, Tennessee 37237
6/1/75 — 5/31/76 (1)
$173,361

Apathy-futility Syndrome in Child Neglect: An Urban View

Norman A. Polansky
School of Social Work
University of Pennsylvania
Philadelphia, Pennsylvania 1910
6/1/75 — 5/30/76 (1)
$175,332

Identification and Definition of Factors Causally Associated with Child Abuse and Neglect

Dr. Arthur H. Green
Department of Psychiatry
Downstate Medical Center
State University of New York
450 Clarkson Avenue
Brooklyn, New York 11203
5/1/75 — 4/30/76 (1)
$125,989

Family Interaction Patterns Related to Child Abuse and Neglect

Dr. Robert L. Burgess
Professor, College of Human Development
The Pennsylvania State University
University Park, Pennsylvania 16802
6/30/75 – 6/29/76 (1)
$109,464

Service Project to Determine Reliability and Validity of Child Rearing Questionnaire

Ray E. Helfer, M. D.
Department of Human Development
Michigan State University
East Lansing, Michigan 48824
6/1/75 – 5/31/76 (1)
$23,000

A Prospective Study of the Antecedents of Child Abuse

Dr. Byron Egeland
Department of Educational Psychology
University of Minnesota
Room N-548, Elliott Hall
Minneapolis, Minnesota 55455
5/1/75 – 4/30/76 (1)
$116,221

An Exploratory Study of Defining and Classifying Cases of Child Abuse

Richard J. Gelles
University of Rhode Island
Kingston, Rhode Island 02881
6/30/75 – 6/29/76 (1)
$30,400

Child Abuse: A Controlled Study of Social, Familial, Individual and Interactional Factors

R. H. Starr, Jr., Ph.D.
Family Center
Children's Hospital of Michigan
3901 Beaubien Boulevard
Detroit, Michigan 48201
6/1/75 – 5/30/76 (1)
$223,324

An Investigation of the Relationship Between Substance Abuse and Child Abuse

Joseph Mayer, Ph.D.
Washingtonian Center for Addiction
Boston, Massachusetts 02130
6/30/75 – 6/29/76 (1)
$124,170

An Investigation of the Effects of a Multidimensional Service Program on Recidivism/Discontinuation of Child Abuse and Neglect

Dr. Roy C. Herrenkohl, Jr.
Center for Social Research
Department of Social Relations
Lehigh University
Bethlehem, Pennsylvania 18015
6/1/75 – 5/31/76 (1)
$106,223

Identification of the Factors Effective in the Discontinuation of Parental Abuse and Neglect

Ann W. Shyne
Child Welfare League of America
67 Irving Place
New York, New York 10003
5/1/75 – 4/30/76 (1)
$93,906

Evaluation Measures for Child Abuse and Neglect Projects

James R. Seaberg, Ph.D.
Center for Social Welfare Research
School of Social Work
University of Washington
Seattle, Washington 98195
6/1/75 – 5/31/76 (1)
$233,607

An Exploratory Investigation of Potential Societal and Intrafamilial Factors Contributing to Child Abuse and Neglect

Dr. Evangeline Ward
National Council for Black Child Development, Inc.
490 L'Enfant Plaza East
Suite 3204
Washington, D. C. 20024
6/1/75 – 5/30/76 (1)
$178,000

San Antonio Child Abuse/Neglect Research Project

Mr. Jose Rendon
Mexican-American Neighborhood
Civic Organization
P.O. Box 7349
San Antonio, Texas 78207
6/30/75 – 6/29/76 (1)
$123,021

Evaluation of Formative Demonstration Centers

Earl F. Doty
E. H. White and Company
347 Clement Street
San Francisco, California 94118
12/31/74 – 9/30/75 (1)
$204,850

Evaluation of Formative Resource Projects

James Gee
Associate Control Research and Analysis, Inc.
1000 Vermont Avenue, N. W.
Washington, D. C. 20005
12/32/74 – 9/30/75 (1)
$191,242

Projects Funded Under Auspices of the Department of Health, Education, and Welfare Intradepartmental Committee on Child Abuse and Neglect

Child Abuse: Formal and Informal Decision-Making Processes

Gail Garinger
Judge Baker Guidance Center
295 Longwood Avenue
Boston, Massachusetts 02115

Completed

Survey of Data on Child Abuse

Jean E. Bedger
Council for Community Services
64 E. Jackson Boulevard
Chicago, Illinois 60604

Completed

Child Abuse and Neglect Programs Under Mental Health Auspices

Douglas Holmes
Community Research Applications, Inc.
33 West 60th Street
New York, New York 10023

Completed

Survey of Nine Health Based Programs for Child Abuse/Neglect

June Lockhart, M. D.
American Academy of Pediatrics
Evanston, Illinois 60204

Completed

Evaluation of Child Abuse/Neglect Demonstration Projects

Fred Collignon
Berkeley Planning Associates
2320 Channing Way
Berkeley, California 94704

9/30/75 – 9/30/76 (2)
$250,000

Child Trauma Intervention Project, UCLA

Morris Paulson
University of California, Los Angeles
405 Hilgard Avenue
Los Angeles, California 90024

7/1/75 – 6/30/76 (2)
$410,184

Behavior, Parenting and Outcome of High Risk Infants

Dr. James Kent
Children's Hospital of Los Angeles
P.O. Box 54700 Terminal Annex
Los Angeles, California 90054

10/1/75 – 3/31/76 (2)
$110,302

Child Abuse in Institutions

Donald McNamee
Eunice Kennedy Shriver Center for Mental Retardation
200 Trapelo Road
Waltham, Massachusetts 02154

7/1/75 – 6/30/76 (2)
$324,718

Mother to Infant Attachment

John H. Kennell
Case Western Reserve University
2040 Adelbert Road
Cleveland, Ohio 44106

7/1/75 – 6/30/76 (2)
$82,000

Follow-Up of Study of Traumatized Children

Elizabeth Elmer
Pittsburgh Child Guidance Center
201 De Soto Street
Pittsburgh, Pennsylvania 15213

Completed

Measures to Predict Child Abuse

Mildred Disbrow
University of Washington
200 Administration Building
Seattle, Washington 98195

7/1/75 – 6/30/76 (2)
$128,243

The Effect of Birth Order on Mother-Child Relationship

Michael Lewis
Educational Testing Service
Rosedale Road
Princeton, New Jersey 08540

7/1/75 – 10/31/76 (2)
$88,825

Correlates of Family Size and Child Spacing

R. L. Nuttal
Boston College
Brighton, Massachusetts 02135

Completed

A Longitudinal Study of Physically Abused Children

Dr. James Kent
Division of Psychiatry
Children's Hospital of Los Angeles
4650 Sunset Boulevard
Los Angeles, California 90054

6/30/75 – 6/30/76 (3)
$124,00

Density and Pathology in Urban Areas

H. M. Choldin
University of Illinois
Urbana, Illinois 61801

9/1/75 – 9/30/76 (2)
$56,132

Modernization through Education of Mother-Child Dyads

D. T. Slaughter
University of Chicago
Chicago, Illinois 60601

6/1/75 – 5/31/76 (2)
$75,623

Other Projects Funded by Federal Agencies

National Institute of Child Health and Human Development

Infant and Maternal Behaviors Regulating Early Growth

Dr. Ernesto Pollitt
Massachusetts Institute of Technology
Cambridge, Massachusetts 02139

Completed

Prince George's County Hotline

Diane Cabot
6100 Rhode Island Avenue
Hyattsville, Maryland 20036

6/23/75 — 3/22/76 (1)
$2,500

Special Approaches in Juvenile Assistance

Marjorie Statman
1743 18th Street, N. W.
Washington, D. C. 20009

6/23/75 — 12/22/75 (1)
$2,500

Youth Emergency Service

Joe Palazollo
9307 Olive Street
Olivette, Missouri 63132

6/23/75 — 3/22/76 (1)
$2,500

Conference on Abused Adolescents

Dr. William Hoffman
Center for Continuing Education in
Social Work
University of Minnesota
2400 Oakland Avenue
Minneapolis, Minnesota 55812

6/23/75 — 12/22/75 (1)
$2,500

National Institute on Alcohol Abuse and Alcoholism

Children of Alcoholics

Dorothy Miller **Scientific Analysis Corporation** **San Francisco, California 94105**	**6/1/75 – 5/31/76 (1)** **$74,000**

Services to Children of Alcoholic Parents and Those Parents

Willem Bosma **Department of Psychiatry** **University of Maryland** **Baltimore, Maryland 21201**	**7/1/75 – 6/30/76 (3)** **$175,000**

Developmental Services for Children of Problem Drinker Parents

Hunter B. Stewart **Committee for Economic Progress, Inc.** **Orangeburg, South Carolina 29115**	**2/1/75 – 1/31/76 (1)** **$110,331**

DEMONSTRATION PROJECTS

Projects Funded by the National Center on Child Abuse and Neglect

Family Resource Center

Richard W. Heim
New Mexico Social Services Agency
Health and Social Services Department
P. O. Box 2348
Santa Fe, New Mexico 87501
6/30/75 – 6/29/76 (2)
$270,000

Family Stress Center

Joseph Wilcox
YMCA Human Development Department
1115 Eighth Avenue
San Diego, California 92101
6/30/75 – 6/29/76 (2)
$150,000

Hawaii Child Abuse Demonstration Center

Sherrell L. Hammar, M. D.
Kauikeolani Children's Hospital
226 North Kaukini Street
Honolulu, Hawaii 96817
6/30/75 – 6/29/76 (2)
$250,000

Family and Child Advocates

Jeanne M. Fox
Evanston Mental Health Services
1601 Sherman Avenue
Evanston, Illinois 60201
6/30/75 – 6/29/76 (2)
$150,000

H.E.L.P. Resource Project for Children and Families

Curtis L. Decker
Maryland Department of Employment
and Social Services
1100 North Eutaw Street
Baltimore, Maryland 21201
6/30/75 – 6/29/76 (2)
$250,000

Multi-State Child Abuse and Neglect/Resource Demonstration Project

George Thomas, Ph.D.
University of Georgia
Tucker Hall
Athens, Georgia 30601
6/30/75 – 6/29/76 (2)
$350,000

Metropolitan Area Protective Services Project

Mary Lee Leahy
Illinois Department of Children and Family Services
524 South Second Street
Springfield, Illinois 62706

7/1/75 – 6/30/76 (2)
$250,000

Urban Indian Child Resource Center

Jennie R. Joe
Indian Nurses of California, Inc.
2680 O'Hare
San Pablo, California 94806

7/1/75 – 6/30/76 (2)
$150,000

Child Abuse and Neglect Demonstration Organization

Charles A. Cass
Central Texas Council of Governments
P.O. Box 729
Belton, Texas 76513

7/1/75 – 6/30/76 (2)
$150,000

Bedford-Stuyvesant Family Services Program

T. George Silcott
The Wiltwyck School
1239-41 Fulton Street
Brooklyn, New York 11216

7/1/75 – 6/30/76 (2)
$250,000

Demonstration Center for Child Abuse and Neglect

Victor C. Vaughn III, M. D.
St. Christopher's Hospital for Children
2600 North Lawrence Street
Philadelphia, Pennsylvania 19133

7/1/75 – 6/30/76 (2)
$190,000

Resource Development for Activities Related to Child Abuse and Neglect in New York State

K. Ronald Bard
Cornell University
NG—14 MUR Hall
Ithaca, New York 14853

6/30/75 – 6/29/76 (2)
$239,999

Connecticut Child Abuse and Neglect Demonstration Center

Francis H. Maloney
Connecticut Department of Children
and Youth Services
345 Main Street
Hartford, Connecticut 06106

7/1/75 – 6/30/76 (2)
$150,000

The Family Development Program

John G. Cosgrove
College of Medicine and Dentistry
of New Jersey
Martland Hospital Unit
Department of Social Services
65 Bergen Street
Newark, New Jersey 07107

7/1/75 – 6/30/76 (2)
$270,000

Children's Hospital National Medical Center
Child Abuse and Neglect Model Center

Robert V. Morin
Research Foundation of Children's Hospital
2125 13th Street
Washington, D. C. 20009

7/1/75 – 6/30/76 (2)
$250,000

Protective Services Resource Institute

Lawrence T. Taft
Rutgers Medical School
Department of Pediatrics
University Heights
Piscataway, New Jersey 08854

6/30/75 – 6/29/76(2)
$300,000

National Urban League Child Abuse Project

Soraya M. Davis
National Urban League, Inc.
Community Development Department
55 East 52nd Street
New York, New York 10022

6/30/75 – 6/29/76 (2)
$298,869

Proposal for a Management Support System to Assist the
Massachusetts Department of Public Welfare

Julius B. Richmond, M. D.
Judge Baker Guidance Center
295 Longwood Avenue
Boston, Massachusetts 02115

7/1/75 – 6/30/76 (2)
$300,000

The Educational System's Role in Child Abuse and Neglect

James H. Peterson
Education Commission of the States
Department of Planning and Development
1860 Lincoln Street
Denver, Colorado 80203

6/30/75 — 6/29/76 (2)
$229,979

A Statewide Program for Maltreated Children

Dean George R. Holcomb
Office of Research Administration
South Building
University of North Carolina
Chapel Hill, North Carolina 27514

6/30/75 – 6/30/76 (2)
$239,050

National Center on Child Abuse and Neglect

Dr. C. Henry Kempe
National Center on Child Abuse
University of Colorado Medical Center
4200 East Ninth Avenue
Denver, Colorado 80220

6/30/75 — 6/29/76 (2)
$262,000

Arizona Community Development for Abuse and Neglect

Dr. Gloria Olson
Department of Economic Security
Bureau of Community Support
P.O. Box 6123
Phoenix, Arizona 85005

6/30/75 — 6/29/76 (2)
$240,000

Region VII Child Abuse and Neglect Resource Center

Dr. William Thiesen
Institute of Child Behavior and Development
University of Iowa
Iowa City, Iowa 52242

6/30/75 — 6/29/76 (1)
$249,343

A Resource Project for Region IX

Mr. Hershel Swinger
California State University, Los Angeles
5151 State University Drive
Los Angeles, California 90032

6/30/75 — 6/30/76 (1)
$270,000

Region X Resource Project for Child Abuse and Neglect

Mr. Elwyn Wenger
Northwest Federation for Human Services
c/o Statehouse
Boise, Idaho 83720

6/30/75 – 6/29/76 (1)
$250,000

Regional Resource Center for Region VI

Dr. Michael L. Lauderdale
The School of Social Work
The University of Texas at Austin
Austin, Texas 78712

6/30/75 – 6/29/76 (1)
$250,100

Regional Resource Center for Region III

Dr. Lawrence E. Cary
Institute for Urban Affairs and Research
Howard University
P.O. Box 191
Washington, D. C. 20059

6/30/75 – 6/29/76 (1)
$249,807

Regional Resource Project Region V

Dr. Catherine S. Chilman
School of Social Welfare
The University of Wisconsin-Milwaukee
Milwaukee, Wisconsin 53201

6/30/75 – 6/29/76 (1)
$250,000

Demonstration Project for Coordinated Delivery of Social Services to Children Residing on a Military Base and in Surrounding Rural Counties

Jean Dycus
Tennessee Department of Public Welfare
Social Services Division
410 State Office Building
Nashville, Tennessee 37219

7/1/75 – 6/30/76 (1)
$146,971

Child Advocacy Resources Expansion

Charla McCoy
Texas Department of Public Welfare
John H. Reagan Building
Austin, Texas 78701

7/1/75 – 6/30/76 (1)
$300,441

Project Ku nak we sha' (Caring)

Maxine W. Robbins
The Yakima Indian Nation
P.O. Box 632
Toppenish, Washington 98948

7/1/75 – 6/30/76 (1)
$169,183

Migrant Child Abuse and Neglect Prevention Project

Oscar L. Villarreal
Texas Migrant Council, Inc.
P.O. Box 917
2220 Station Ursula
Laredo, Texas 78040

7/1/75 – 6/30/76 (1)
$173,894

Cook Inlet Native Association Child Abuse and Neglect Program

Robert W. Rude
Cook Inlet Native Association
P.O. Box 515
Anchorage, Alaska 99510

7/1/75 – 6/30/76 (1)
$141,024

Child Abuse and Neglect Service Project

Betty Bay
Montana Department of Social and Rehabilitation Services
P.O. Box 1723
Helena, Montana 59601

7/1/75 – 6/30/76 (1)
$162,407

Developing a Community of Child Care and Concern for Native American Children and Families

John Red Horse
University of Minnesota
Center for Urban and Regional Affairs
311 Walter Library
Minneapolis, Minnesota 55455

7/1/75 – 6/30/76 (1)
$165,993

Choctaw Center on Child Abuse and Neglect

Phillip Martin
Mississippi Band of Choctaw Indians
Route 7, Box 21
Philadelphia, Mississippi 39350

7/1/75 – 6/30/76 (1)
$174,649

Appalachian Citizens for Children's Rights

Patricia M. Keith
Family Service Association
364 High Street
Morgantown, West Virginia 26505
7/1/75 — 6/30/76 (1)
$125,090

Demonstration Project for Child Abuse and Neglect

Dr. Bruce D. Graham
The Children's Hospital Research Foundation
561 South 17th Street
Columbus, Ohio 43205
6/30/75 — 6/29/76 (1)
$250,000

Regional Child Abuse Treatment and Referral Demonstration Center

William Galvagni
Norton-Children's Hospital, Inc.
200 East Chestnut Street
Louisville, Kentucky 40202
6/30/75 — 6/29/76 (1)
$250,000

Clayton County Protective Service Team

Anne T. Plant
Clayton County Department of Family
and Children Services
129 King Street
Jonesboro, Georgia 30236
6/30/75 — 6/29/76 (1)
$250,000

Child Abuse and Neglect Demonstration Center

Cassandra Smith
City of Detroit - Youth Department
2 Woodward
Detroit, Michigan 48226
6/30/75 — 6/29/76 (1)
$250,000

Parental Stress Center

Harold Luebs
Children's Hospital of Pittsburgh
125 DeSoto Street
Pittsburgh, Pennsylvania 15213
6/30/75 — 6/29/76 (1)
$250,000

Projects Funded Under Auspices of the Department of Health, Education, and Welfare Intradepartmental Committee on Child Abuse and Neglect

The Family Learning Center Project

Margaret Nicholson
Adams County Department of Social Services
4200 E. 72nd Avenue
Commerce City, Colorado 80022

5/1/75 – 4/30/76 (2)
$206,694

A Protective Service System - Union County, New Jersey

Bonnie Ludlow
State of New Jersey - Division of Youth and
Family Services
1155 Magnolia Avenue
Elizabeth, New Jersey 07207

5/1/75 – 4/30/76 (2)
$198,922

Family Resource Center

Gregory Eschele
The Family Resource Center
St. Louis Children's Hospital
St. Louis, Missouri 63108

5/1/75 – 4/30/76 (2)
$160,026

Makah Child Development Services Center

Mary Jo Butterfield
Makah Tribal Council
P.O. Box 507
Neah Bay, Washington 98357

5/1/75 – 4/30/76 (2)
$30,672

Coordinating Community Concern for Child Abuse

Gary D. Matthies
The Panel for Family Living
420 South L Street
Tacoma, Washington 98405

5/1/75 – 4/30/76 (2)
$116,195

Arkansas Child Abuse and Neglect Project

Janet Knight
Arkansas Social Services
P.O. Box 1437
Little Rock, Arkansas 72203

5/1/75 – 4/30/76 (2)
$219,541

Child Abuse/Neglect Demonstration Unit

Doris Gonzalez Knudson
Department of Social Services
P.O. Box 11398
San Juan, Puerto Rico 00908

5/1/75 — 5/30/76 (2)
$156,527

Child Protection Center

Jeannette Hendrix
Louisiana Community Coordinated Child Care
State Department of Education
P.O. Box 44065
Baton Rouge, Louisiana 70804

5/1/75 — 4/30/76 (2)
$178,580

Family Care Center

Robert Greenberg, M. D.
Charles R. Drew Postgraduate Medical School
1621 E. 120th Street
Los Angeles, California 90059

5/1/75 — 4/30/76 (2)
$156,645

Parent and Child Effective Relations Project

Charlene Bennett
Juvenile Welfare Board of Pinellas County
3455 First Avenue South
St. Petersburg, Florida 33711

5/1/75 — 4/30/76 (2)
$126,512

Pro-Child: A Child Abuse and Neglect Program

Julia Kanwit
Arlington County Board of Public Welfare
P.O. Box 7258
Arlington, Virginia 22207

5/1/75 — 4/30/76 (2)
$128,288

Other Projects Funded by Federal Agencies

National Institute on Drug Abuse

The New York Medical College Program for Pregnant Addicts and Addicted Mothers

Dr. Richard Brotman, M. D.
New York Medical College
5 East 102nd Street
New York, New York 10029

3/1/75 – 4/30/76 (1)
$500,000

Women's Center/Detroit-Wayne County Mental Health Board

Ms. Jane Mannette
W.O.M.A.N. Center
4105 Cass
Detroit, Michigan 48201

7/1/75 – 6/30/76 (2)
$371,912

Women, Incorporated (Boston)

Ms. Patricia Ready
Women, Inc.
134 Mt. Auburn Street
Cambridge, Massachusetts 01432

1/1/75 – 12/30/75 (1)
$220,510

The Odyssey House Parents' Demonstration Program

Dr. Judeanne Densen Gerber, M. D.
Odyssey House
309-311 East 6th Street
New York, New York 10003

8/1/75 – 7/31/76 (2)
$754,000

EDUCATIONAL TRAINING AND TECHNICAL ASSISTANCE

Projects Funded by the National Center on Child Abuse and Neglect

Child Abuse and Neglect Curriculum Development

Noel Day
Urban and Rural Systems Associates
Pier 1-1/2
San Francisco, California 94111
12/31/74 – 6/29/76 (1)
$597,026

Assessment of Training and Technical Assistance Requirements of Child Abuse and Neglect Programs and Activities

Eddie A. Taylor
Development Associates, Inc.
1521 New Hampshire Avenue, N. W.
Washington, D. C. 20036
7/1/75 – 1/27/76 (1)
$461,338

Provision of Technical Assistance in the Development and Improvement of Child Abuse and Neglect Reporting Systems and Central Registers

Quinn Shelton
National Institute for Community Development
2021 K Street, N. W.
Washington, D. C. 20006
7/1/75 – 12/31/76 (1)
$560,857

Training of Selected Personnel from Organizations and Agencies Having Child Abuse and Neglect Responsibilities in Regions VI-X and Among Indian Populations

David Boorkman
Urban and Rural Systems Associates
Pier 1-1/2
San Francisco, California 94111
7/1/75 – 4/6/76 (1)
$501,122

Provision of Training of Selected Personnel from Organizations and Agencies Having Child Abuse and Neglect Responsibilities in Regions I-V

Robert MacDicken
Kirschner Associates, Inc.
733 15th Street, N. W.
Washington, D. C. 20005
7/1/75 – 4/6/76 (1)
$457,994

Provision of Technical Assistance in the Development of Child Abuse and Neglect Public Awareness Programs and Materials

William G. Moore Joseph A. Davis Consultants, Inc. 104 E. 40th Street, Suite 203 New York, New York 10016	7/1/75 – 6/30/76 (1) $306,539

State Child Abuse and Neglect Grant Program

Robert C. Harder Kansas Department of Social and Rehabilitation Services State Office Building Topeka, Kansas 66618	6/30/75 – 6/29/76 (1) $38,567

Projects Funded Under Auspices of the Department of Health, Education, and Welfare Intradepartmental Committee on Child Abuse and Neglect

Development of Training Models for the Identification, Treatment and Prevention of Child Abuse and Neglect

Sherrell Munce
Children's Hospital Medical Center
Children's Trauma Center
51st and Grove Street
Oakland, California 94609

Completed

A Multi-disciplinary Approach to Educational Problems Associated with Child Abuse and Neglect (Project Protection)

Diane Broadhurst
Montgomery County Public Schools
850 Hungerford Drive
Rockville, Maryland 20850

7/1/75 – 6/30/76 (2)
$20,000

Child Abuse: A Multi-disciplinary Interagency Program for Identification and Referral

Stuart McKenty
Consortium C, EPD
202 North Loop West
Houston, Texas 77018

7/1/75 – 6/30/76 (2)
$90,000

The Abused, Maltreated and Neglected Child

Nathan Gross
New York City Board of Education
Community School District No. 18
545 Utica Avenue
Brooklyn, New York 11203

7/1/75 – 6/30/76 (2)
$135,000

Workshop on Protective Services for Children

Edward J. Durnall
Division of Continuing Education
University of New Hampshire
Durham, New Hampshire 03824

8/5/74 – 8/9/75 (1)
$9,445

Other Projects Funded by Federal Agencies

National Institute on Alcohol Abuse and Alcoholism

Family Therapy Training

David Berenson
Center for Family Learning
New Rochelle, New York 10805
6/1/75 – 7/31/76 (1)
$33,081

Community Program for Families with Problem Drinkers

Peggy Papp
Center for Family Learning
New Rochelle, New York 10805
11/1/75 – 10/31/76 (2)
$68,000

Social and Rehabilitation Service

National Training Project on Child Abuse and Neglect

Dr. Alexander G. Zaphiris
Graduate School of Social Work
University of Denver
Denver, Colorado 80210
Completed

Regional Training Program on Child Abuse and Neglect

Dr. Alexander G. Zaphiris
Graduate School of Social Work
University of Denver
Denver, Colorado 80210
Completed

California State-Wide Training in Child Abuse

Sharrell Munce
Children's Trauma Center
Children's Hospital Medical Center
51st Grove Streets
Oakland, California 94609
Completed

Child Abuse Education and Training Program

Charles F. Mitchell
Associate Professor
School of Social Work
609 Clark
University of Missouri
Columbia, Missouri 65201
Completed

Training in the Area of Child Abuse and Neglect

Duane Thomas
Social Service Division Medical Center
University of Kansas
39th and Rainbow Bend
Kansas City, Kansas 66103

Completed

Southwest Indiana Child Abuse and Neglect Training Project

Charles D. Holbrook
Assistant Professor of Social Work
University of Evansville
P.O. Box 329
Evansville, Indiana 47702

Completed

Training for Strengthening Parental Skills

Harry Brown
Dean of Continuing Education
Illinois Valley Community College
Rural Route 1
Oglesly, Illinois 61348

Completed

Dynamics of Effective Parenting

Jacqueline Michael
Coordinator, Community Education Program
College of Community Services
University of Cincinnati
312 French Hall
Cincinnati, Ohio 45221

Completed

Crisis Intervention and Critical Incident Handling

Marian I. Reavey
Associate Professor, School of Social Work
Wayne State University
Detroit, Michigan 48202

Completed

A Social Systems Approach to Child Neglect and Abuse

Willie R. Berry
Associate Professor
Department of Sociology and Anthropology
Western Kentucky University
Bowling Green, Kentucky 42101

Completed

Training Workers for Service to Abused and Neglected Children

Lester J. Glick
Dean, School of Social Work
University of Southern Mississippi
Box 114, Southern Station
Hattiesburg, Mississippi 39401

Completed

Intensive Training in Child Protective Services

Dr. Ethelyn R. Strong
Social Work Department
Norfolk State College
2401 Corprew Avenue
Norfolk, Virginia 23504

Completed

Institute on Child Neglect and Abuse

Fred Delli Quadri
Dean, School of Social Work
The University of Alabama
P.O. Box 2846
University, Alabama 35486

Completed

Training in Child Abuse and Neglect

Martin Nacman
Director, Social Work Division
Department of Health Services
School of Medicine and Dentistry
University of Rochester
Rochester, New York 14642

Completed

Training Project in Protective Services for Children

Lillian Lampkin
Dean, School of Social Work
Hunter College
129 East 79th Street
New York, New York 10021

Completed

INFORMATION GATHERING AND DISSEMINATION

Projects Funded by the National Center on Child Abuse and Neglect

National Incidence Study

Marvin Burt
Burt Associates, Inc;
7315 Wisconsin Avenue
Bethesda, Maryland 20014

12/31/74 — 7/30/75 (1)
$107,117

Clearinghouse on Programs and Summarization of Research on Child Abuse and Neglect

Douglas Berninger, Ph.D.
Herner and Company
2100 M Street, N. W.
Washington, D. C. 20037

12/23/74 — 6/22/76 (1)
$494,014

Projects Funded Under Auspices of the Department of Health, Education, and Welfare Intradepartmental Committee on Child Abuse and Neglect

National Clearinghouse for Child Abuse and Neglect

Vincent De Francis, J.D.
The American Humane Association
(Children's Division)
P.O. Box 1266
Denver, Colorado 80201

4/1/75 — 3/30/76 (2)
$194,721

Structure and Performance of Programs of Child Abuse and Neglect

Dr. Saad Z. Nagi
Ohio State University
1250 Chambers Road
Columbus, Ohio 43212

7/1/75 — 6/30/76 (2)
$75,000

Revision of the 1962 Model Child Abuse (and Neglect) Reporting Law

Alan Sussman
Institute of Judicial Administration
40 Washington Square South
New York, New York 10012

Completed

Parents Anonymous Self-Help for Child Abusing Parents

Leonard L. Lieber
Parents Anonymous
2930 Imperial Highway
Suite 332
Inglewood, California 90303

5/1/75 — 4/30/76 (2)
$271,246

State of Knowledge of Child Neglect

Dr. Norman A. Polansky
Regional Institute of Social Welfare Research
University of Georgia
1260 South Lumpkin
Athens, Georgia 30602

Completed

Development of Evaluation System for Measuring Cost Effectiveness of Protective Services

Dr. Marvin Burt
Burt Associates, Inc.
7315 Wisconsin Avenue
Bethesda, Maryland 20014

7/1/75 – 6/30/76 (2)
$200,000

Early Warning Signals of Serious Neglect and Abuse

Jeanne M. Giovannoni
School of Social Welfare
University of California, Los Angeles
405 Hilgard Avenue
Los Angeles, California 90024

6/29/75 – 6/28/76 (2)
$252,000

Other Projects Funded by Federal Agencies

Law Enforcement Assistance Administration
Department of Justice

Juvenile Justice Standards Project

Paul Nejelski
Institute of Judicial Administration
33 Washington Square
New York, New York 10011

5/22/75 – 7/22/76 (2)
$347,864

Physical Child Abuse Prescriptive Package

Arnold Schuchter
Center for Community Resource Development
Boston University
710 Commonwealth Avenue
Boston, Massachusetts 02215

3/15/75 – 11/14/75 (1)
$60,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

CHARTER

Advisory Board on Child Abuse and Neglect

PURPOSE

The Advisory Board on Child Abuse and Neglect shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under P.L. 93-247 with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.

AUTHORITY

Public Law 93-247. The Advisory Board is governed by Section 6(a) of P.L. 93-247, the "Child Abuse Prevention and Treatment Act."

FUNCTION

The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect administered or assisted under P.L. 93-247 with such programs and activities administered or assisted by the Federal Agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal Standards for child abuse and neglect prevention and treatment programs and projects.

STRUCTURE

The Advisory Board shall consist of the Assistant Secretary for Human Development; or his designee, as Chairman and not more than twenty members selected by the Secretary from Federal Agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, the Health Services Administration, the Department of Justice (Law Enforcement Assistance Administration), the Department of Interior (Bureau of Indian Affairs), and the Department of Defense.

Members shall be invited to serve for eighteen-month terms; terms of more than eighteen months are contingent upon the renewal of the Advisory Board by appropriate action prior to its termination.

Management and staff services shall be provided by the Office of Child Development and the Acting Associate Chief of the Children's Bureau or his designee, who shall serve as the Executive Secretary.

MEETINGS

Meetings will be held bi-monthly at the call of the Chairman, who shall also approve the agenda.

648

DELEGATION OF AUTHORITY OF CHAIRMANSHIP OF THE ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

Effective immediately, I hereby delegate to the Assistant Secretary for Human Development authority to serve as Chairman of the Advisory Board of Child Abuse and Neglect. This authority may be redelegated; redelegation will be effected by memorandum, copies of which will be delivered to the Department Committee Management Officer within five business days.

March 29, 1974
Date

Caspar W. Weinberger
Secretary

DELEGATION OF AUTHORITY TO INVITE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE MEMBERS TO SERVE ON THE ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

Effective immediately, I hereby delegate to the Assistant Secretary for Human Development authority to invite Department of Health, Education, and Welfare members to serve on the Advisory Board on Child Abuse and Neglect.

March 29, 1974
Date

Caspar W Weinberger
Secretary

REPORTS

The Advisory Board shall prepare and submit, through the Secretary, no later than August 1, 1975, a report to the President and the Congress on the programs assisted under P.L. 93-247 and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal Agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.

An annual report shall be submitted to the Secretary through the Assistant Secretary for Human Development not later than June 30 of each year, which shall contain, as a minimum, a list of members and their business addresses, the Advisory Board's functions, dates and places of meetings, and a summary of the Advisory Board's activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

TERMINATION DATE

Unless renewed by appropriate action prior to its expiration, the Advisory Board will terminate eighteen months from the date this charter is approved.

APPROVED:

March 29,1974
Date

Caspar W Weinberger
Secretary

ADVISORY BOARD

CHILD ABUSE PREVENTION AND TREATMENT ACT

P. L. 93-247

Office of Child Development

Saul R. Rosoff, Acting Director
Office of Child Development
Donohoe Building - Room 5030
400 6th Street, S. W.
Washington, D. C. 20024
755-7762

Frank Ferro, Acting Associate Chief
Children's Bureau
Office of Child Development
Donohoe Building - Room 5163
400 6th Street, S. W.
Washington, D. C. 20024
755-7418

Office of Education

Betty Fogg, Program Officer
Office of Education
GSA - ROB No. 3
Room 3616
7th and D Streets, S. W.
Washington, D. C. 20202
245-2255

Dr. Robert Weatherford, Special Assistant
to the Commissioner
Office of Education
FOB No. 6 - Room 4181
400 Maryland Avenue, S. W.
Washington, D. C. 20201
245-9251

National Institute of Education

David Bossel, Research Associate
National Institute of Education
1200 19th Street, N. W.
Washington, D. C. 20208
245-5170

Michael O'Malley, Research Associate
National Institute of Education
1200 19th Street, N. W.
Washington, D. C. 20208
254-5058

Office of the Assistant Secretary for Health

Patricia Johnson
Office of Pediatric Affairs
Department of Health, Education, and
Welfare Room 4075
330 Independence Avenue S. W.
Washington, D. C. 20201
245-6931

ADAMHA/National Institute of Mental Health

Ira S. Lourie, M. D.
NIMH
Parklawn Building - Room 12-105
5600 Fishers Lane
Rockville, Maryland 20852
443-3533

Giesela Meloy, M. D.
NIMH
Parklawn Building - Room 12C-24
5600 Fishers Lane
Rockville, Maryland 20852
443-3556

NIH/National Institute of Child Health and Human Development

Joseph M. Bobbitt, Ph.D.
Assistant Director of Behavioral Science,
OPPE/NICHD
NIH - Building 31 - Room 2A-22
9000 Rockville Pike
Bethesda, Maryland 20014
496-1877

Felix de la Cruz, M. D.
Special Assistant for Pediatrics
Mental Retardation Program
Landow Building - Room C-708
7910 Woodmont Avenue
Bethesda, Maryland 20014
496-1383

Health Services Administration

Virginia Insley
Chief, Medical Social Work Section, BCHS
Parklawn Building - Room 12A-17
5600 Fishers Lane
Rockville, Maryland 20852
443-4026

Henriette Villaescusa
Division of Clinical Services, BCHS
Parklawn Building - Room 12A-08
5600 Fishers Lane
Rockville, Maryland 20852
443-3163

Social and Rehabilitation Service

Mildred Arnold
Assistant to the Commissioner, CSA
Mary E. Switzer Building - Room 2014
330 C Street, S. W.
Washington, D. C. 20201
245-0239

Johnnie Brooks
Acting Assistant Commissioner for
Program Development and Implementation
Mary E. Switzer Building - Room 2226
330 C Street, S. W.
Washington, D. C. 20201
245-9415

Department of Defense

Colonel Edward J. Huycke, MS, USA
Director for Professional Services
Pentagon - Room 3E181
Washington, D. C. 20301
697-9658

Lieutenant Colonel James A. Granger, MC, USA
Chief, Child Psychiatry Section
Walter Reed Army Hospital Center
Washington, D. C. 20012
576-5421

Department of Interior

Clare G. Jerdone
Principal Child Welfare Specialist
Bureau of Indian Affairs
Department of Interior
Washington, D. C. 20245
343-7911

Janice Johnson
Staff Assistant for Education and
Social Affairs
Office of Territorial Affairs
Bureau of Indian Affairs
Department of Interior
Washington, D. C. 20245
343-4707

Department of Justice

Stanley Pottinger
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Office of Human Development/Office of Child Development

National Center on Child Abuse and Neglect

Statement of Organization and Functions

The Statement of Organization and Functions for the National Center on Child Abuse and Neglect (subchapter 1R40) is amended to include the branch level organization and functions. The mission, organization, and functions are as follows:

1R40203.00 *Mission.* The National Center on Child Abuse and Neglect acts as the principal focus within OCD and the Department for development of policies, advice and plans (including input to the OHD Long Range Plan) on programs relating to the prevention, identification and treatment of child abuse and neglect.

1R40203.10 *Organization.* The Director, National Center on Child Abuse and Neglect, reports directly to the Associate Director of the Children's Bureau, Office of Child Development. The Center consists of:

A. Immediate Office of the Director

B. Program Policy and Planning Branch

C. Clearinghouse Branch

1R40203.20 *Functions.*

A. Immediate Office of the Director

1. Provides leadership and direction to the Center staff and assures coordination among its components.

2. Directs the overall assistance and guidance of the Center to Regional Offices, conveys program and technical assistance objectives to the Regional Offices and reviews Regional work plans and activities related thereto.

3. Assures coordination of Center activities with other elements of the Office of Child Development and with other agencies with activities in the area of child abuse and neglect.

B. Program Policy and Planning Branch

1. Jointly with the Research and Evaluation Division, develops policies, priorities, plans and objectives for research and demonstration activities authorized by P.L. 93-247. Develops and proposes input to the annual OCD Research and Demonstration plan as it relates to child abuse and neglect projects.

2. Provides staff support to the Advisory Board on Child Abuse and Neglect in the conduct of its responsibilities, including the areas of standards development, reports preparation and program coordination.

3. Receives, processes and reviews, either through the Regional or Headquarters office, all applications for demonstration grants and arrangements for demonstration contracts authorized to prevent, identify and treat child abuse and neglect, and makes recommendations thereon to the Director, OCD.

4. In concert with the Social and Rehabilitation Service, monitors compliance with appropriate clauses of The Child Abuse Prevention and Treatment Act of State programs conducted under the authority of part A or B of Title IV of the Social Security Act.

5. Coordinates child abuse and neglect training and technical assistance:

   (a) Monitors Regional Office activities and administration of grants and contracts and provision of training and technical assistance under P.L. 93-247.

   (b) Develops and proposes plans, priorities and objectives for training and technical assistance related to child abuse and neglect and, if approved, may provide or obtain directly or through grants or contracts specialized professional expertise and knowledge for identification, design or provision of such training and technical assistance in specialized areas of competence.

C. Clearinghouse Branch

1. Provides data input and assistance to other elements of the Center and of the Department.

2. Develops, maintains, revises, and manages program clearinghouse data.

3. Elicits information needed for continuous revision and updating of the information base and for planning of management information systems, especially regarding programs.

4. Compiles and prepares information and materials for publication through the Public Education Division of the Children's Bureau.

5. Develops computer-based system and prepares and updates for publication annual summary of recently conducted and currently conducted research on child abuse and neglect.

6. Provides States and local agencies with information and obtains information from them to enlarge the clearinghouse data base.

7. Develops and monitors grants and contracts related to information management.

8. Analyzes and organizes information for Federal-level users.

9. Identifies information gaps and establishes priorities for States' information collection.

10. Provides States and public and non-profit agencies with assistance on the kinds of program information available and how it can be used.

11. Maintains liaison with Federal, State and other information systems to avoid duplication of efforts and improve data bases.

Oct. 7, 1974

Assistant Secretary for
Human Development